The Role Of The Ancillary Worker In The Hospital Service

Thesis

UNRESTRICTED

THE ROLE OF THE ANCILLARY WORKER IN THE HOSPITAL SERVICE

ARTHUR ROYSTON DAVIES , BSc . (Hons), Cert Ed ,
Cert Personnel Management .

Thesis offered for the degree of M . Phil .
(Sociology)

September , 1984 .

Date of submission : 5 December 1983
Date of award : 27 September 1984

TABLE OF CONTENTS

	Page
ABSTRACT	iv
LIST OF TABLES	v
PREFACE	vii
INTRODUCTION AND CHAPTER ONE	1
The Concept of Personal Service Orientation	
The determinants of personal service orientation - Other concepts of work orientation - Extrinsic and intrinsic expectations - Personal service professionals - Nurses - Aides and ancillaries	
CHAPTER TWO	33
The Role of Nurses, Aides and Ancillaries	
Intrinsic involvement in nursing work - Empathising with patients - Professional integrity - Intrinsic involvement: Aides and ancillaries - Empathising with patients - Occupational integrity	
CHAPTER THREE	71
The Role of the Ancillary Worker	
The sample - Occupational characteristics - Intrinsic involvement in ancillary work - Concerned empathy in ancillary work	
CHAPTER FOUR	104
The Ancillary Workers' Involvement in the Personal Service Professional Culture	
Relationships between ancillaries with medical and nursing groups - Relationships with consultants and doctors - Relationship with nursing groups	
CHAPTER FIVE	127
Role Strain in Ancillary Work	
Forms of role strain - Role Strain in ancillary work - Role strain and patient relationships - Intrinsic involvement and role strain - Measuring role strain - Personal service orientation	

CHAPTER SIX 198

The Social and Economic Aspirations of Ancillary Workers

Occupational identity and status - Negotiating para-professional status: The theatre assistants - Economic aspirations - Wages - Industrial disputes - Labour turnover and absenteeism - Change in the hospital work culture

CHAPTER SEVEN 275

Conclusion

The theoretical issues - The practical implications

APPENDICES 320

NOTES AND REFERENCES 354

BIBLIOGRAPHY 372

A B S T R A C T

This study is concerned with defining the nature of the hospital ancillary workers' role. It sets out to establish whether or not ancillaries who are involved in a personal service cultural work situation learn to maximise their skills, knowledge, and empathy under the tutelage of such personal service professionals as doctors and nurses.

There is a need to know the extent to which the relationships between personal service professionals and their aides is an important determinant of the ancillaries orientation to their work. We also need to know if this orientation is one that is peculiar to caring work and takes the form of work involvement defined by Halmos in his book, 'The Personal Service Society', Constable 1970, as 'personal service orientation'. Or do ancillaries develop similar work expectations and aspirations to industrial workers in manual type occupations?

It has been argued that the nature of the hospital sub-culture has been largely shaped by the values of the personal service professionals, particularly the medical professional groups. Is there any evidence that the aspirations of ancillaries and other non-professional groups are introducing new elements into the hospital work culture?

This study establishes that too much emphasis has been placed on the influence of personal service professionals as key people who are primarily concerned with enhancing, and maximising the contribution of their aides and ancillaries and not enough attention has been placed upon the collective aspirations of ancillaries, who want to improve their status in hospitals.

It also establishes that hospitals like factories are work situations which can experience pluralistic conflicts between occupational groups and also a sharper form of conflict between employees at all levels with the State and their agencies the Area Health Authorities.

List of Tables

Table Number		Page Numbers
1	Population Sample	76
2	The Most Important Consideration that influenced Ancillaries to take a Hospital Job	87
3	The Most Satisfying Aspect of the Ancillary Worker Job.	89
4	The Ancillary Workers' Perception of their Contribution to Patient Care	90
5	The Degree of Self Realisation that Ancillary Workers' expressed in their Work.	91
6	The Degree of Workplace Participation Experienced by Ancillaries	94
7	The First Value of Personal Service Orientation: Intrinsic Involvement in Work.	95
8	The Degree to which Ancillaries Know or Want to Know Patients.	98
9	Attitudes Towards the Appreciation of Consultants	105
10	Attitudes Towards the Appreciation of Other Doctors	106
11	The Degree to which Ancillaries meet Nurses in their Work.	112
12	The Degree to which Ancillaries got on well with Nurses.	113
13	Attitudes towards the Appreciation of Senior Nurses	114
14	Attitudes towards The Appreciation of other Nurses	114
15	The Degree of Encouragement that Ancillaries considered they receoved from Nurses.	117
16	The Extent to which Ancillaries do not want to be involved with Patients.	190
17	The Degree of Role Strain Experienced by Five Ancillary Occupational Groups	191
18	The Relationship between Intrinsic Involvement in Work and Role Strain fro all Ancillary Workers	193
19	The Degree of Personal Service Orientation Expressed by Ancillary Groups	195
20	Industrial Disputes in the Health Service	227
21	Hourly Rates, Weekly Earnings and Hours Worked for Male Workers in 1974.	228
22	Hourly Rates, Weekly Earnings and Hours Worked for Female Workers in 1974	229
23	Hourly Rates, Weekly Earnings and Hours Worked for Male and Female Workers in 1981	230
24	Earnings of Employees who received Shift Premium Payments in 1981	232

Table Number		Page Numbers
25	The Percentage of Low Income Earners in 1974 and 1981, Male and Females.	234
26	Industrial Disputes Statistics for the Periods Preceding and Following the Years 1972 and 1973	238
27	The Attitudes of Ancillary Workers in the Hospitals to Industrial Sanctions	247
28	The Yearly Rate of Labour Turnover for Ancillaries over a Three Year Period	262

Preface

This thesis is concerned with the role of the ancillary worker in the hospital service. We are aware of the work of the nurse and the doctor in the hospital service, but in my opinion we do not know enough about the work of the ancillaries.

In the area of social work, education, probation work, community care and medicine we find that the personal service professionals have depended a great deal upon non-professional workers to relieve them of certain duties and tasks. The pressure upon professional workers to deal with administrative duties and technical tasks, has meant that they have had to delegate some of their more routine tasks and duties to personal service aides and ancillaries.

There is a need to examine the extent to which the aides and ancillaries that support the personal service professionals receive the appropriate degree of training for their work.

The work of many ancillaries in hospitals has been developed upon the basis of technical and manual tasks. Sometimes these tasks bring ancillaries into direct contact with patients. Ward orderlies, ambulance workers, theatre assistants, porters, and domestics fall into this category. Because of the contact that ancillaries establish with patients they are often in a position to reinforce the type of emotional support that doctors, nurses and para-medical professionals provide for patients.

The emotional support provided by ancillaries was recognised in the report published by the Central Health Services Council in 1976 on 'The Organisation of the In-Patients Day'. This report made a number of significant points when referring to the emotional needs of children in hospital:

> A very special group are the house staff - nursing aides, ward orderlies, domestic assistants and not forgetting the porters - who should also be a real part of the ward team. Given the right temperament, and with full acceptance by the nursing and medical team, they can make an important contribution to the happiness of the children and the comfort of their parents. They are especially valuable with parents who feel unable to express themselves, or to grasp what is going on. *

* H.M.S.O. Report of a Committee of the Central Health Services Council 1976

> That the in-patient of today is normally in hospital for a shorter time, and his treatment tends to be more intensive and sophisticated than was the case some years ago. Medical and nursing staff are themselves subject to more onerous educational demands and standards, and whether we like it or not the time available for direct contact with patients is less than it used to be.
>
> We believe that no-one in contact with the patient should feel inhibited about passing on relevant, authentic information to the therapeutic team. For example, home helps and ambualce crews have often been able to give valuable information about patients unable to speak for themselves, and some patients have been known to talk more easily to the house-keeping staff than to the doctors or senior nursing staff.

In view of this Report there is a strong case for considering the nature of the contribution of those ancillary occupational groups who contribute to the therapeutic treatment of the patients through their involvement in a therapeutic team. We also need to know the extent to which the ancillaries benefit from the support and tutlage of the medical and nursing groups that play a decisive leadership role in the therapeutic teams.

A study of the work role of the ancillary worker in the therapeutic teams of hospitals is also of theoretical significance. Such a study provides the opportunity to test some of the hypotheses presented by such personal service sociologists as Halmos, who argued that medical and nursing groups would play a decisive role in nurturing the contribution of aides and ancillaries, and enabling them to maximise their contribution to patient care.

Ancillaries and aides who participated in the type of therapeutic milieu described in the Central Health Services Council's report would be participating in what Halmos referred to as a 'personal service professional culture'.

INTRODUCTION AND CHAPTER ONE

THE CONCEPT OF PERSONAL SERVICE ORIENTATION

My interest in the concept of personal service orientation emerged out of the discussions that I had with the late Paul Halmos who was good enough to serve as my external supervisor when I enrolled as a post graduate student at The Open University. Paul Halmos was very interested in the work of the personal service professionals and had written a book on the subject, 'The Personal Service Society', published by Constable in 1970. He suggested to me that it would be a valuable contribution to sociology if I undertook some empirical research to test the validity of the main hypotheses that he presented in his book. He was particularly interested in such empirical research because he was aware of the limitations of his own arguments which were mainly based on documentary evidence.[1]

Halmos clearly defined the cardinal features of the personal service professional workers' role:

> Professions whose principal function is to bring about changes in the body or personality of the client are the personal service professionals, whilst all other professions which are not charged with the responsibilities of this sort, or at any rate, which do not set themselves such tasks as these, are the impersonal service professions. [2]

Halmos[3] argued that personal service professionals and the aides and ancillaries that supported them would work in an environment that was dominated by humanitarian ideals, which would influence occupational behaviour. He made this point: "ideals become the causes of action even when they are rationalisations or ideologies". He maintained that irrespective of the reasons why people chose to work in a personal service

occupation they would learn to express the ideals of the personal service professional culture that they were involved in.[3]

Within such a work culture personal service workers would be encouraged to work away at the role and by cultivating certain aspects of it, refine it or at *least orientate it in the ideal direction* dictated by the role itself. In this introductory chapter I will describe the concept of 'personal service orientation' defined by Halmos in his book 'The Personal Service Society'.[4] I will also consider the determinants of personal service orientation that Halmos considered to be so important.[5]

Halmos argued that personal service professionals would be "cultivating and orientating their role in the ideal direction" when relating their efforts to caring for the clients and patients that they were responsible for. Personal service professionals would direct their energies to attain the highest possible standards of skill and knowledge to provide this care. They would strive to: "maximise their performance" and through such efforts they would derive a high degree of intrinsic satisfaction.[6]

It is evident that the motivation to work effectively in the caring role is an intrinsic form of motivation that has been recognised by other sociologists and psychologists who have examined patterns of work behaviour. Herzberg[7] and Maslow[8], in their studies, illustrate these forms of intrinsic involvement in work on the basis of their studies in industry and commerce.

Halmos argued that the intrinsically satisfying work activities of the personal service professionals were based on three values.[9] Halmos defined the three values in the following terms:

First the value attached to securing the maximal possible knowledge and skill for the performance of the task; this leads to the maximisation of mastery.

Secondly the value attached to a dispassionate yet maximally sensitive empathic consideration of the clients needs, personality and circumstances; this leads to the maximisation of concerned empathy, or at least an untiring alertness and openness to experience this.

Thirdly the value attached to the subordination of the role system to the professional role, an identification of the personality with that role effected through a constantly perfected 'style' of performance which credibly and plausibly impresses upon the client that the first two values are being diligently met and consistently advanced in his interest; this leads to the maximisation of professional integrity.[10]

Halmos was quite clear in his book, 'The Personal Service Society', that personal service professionals who strived to maximise their contribution in relation to the tasks and personal relationships with patients would derive a strong degree of intrinsic satisfaction from their caring work.[11]

Halmos recognised that there would be occasions when "more selfish interests will influence the role behaviour of personal service professionals" and he appreciated the fact that they would want material and status rewards, but he argued, "the overriding consideration of the dedicated personal service professional is to serve others". He then made this significant point:

> The personal service professional would probably want to do the work even if fewer extrinsic rewards were available and that the work rewards are either equal or superior to the best rewards that life can offer.[12]

It is evident that the personal service professional's orientation to his work can be clearly distinguished from the instrumentally orientated workers described by Goldthorpe *et al.*[13] These workers in industrial situations perceived their work in instrumental terms, "work is a means to an end", the end being income from the employer to maintain a desired life style. The two different concepts of work orientation suggest that the influence at work in the personal service professional culture differ significantly from industrial culture. It is worth considering the determinants of this personal service orientation.

The determinants of personal service orientation

If we now consider the determinants of personal service orientation we can appreciate the importance that Halmos attached to the socialising influences of the personal service professional culture.[14] Whilst Halmos recognised the importance of the intrinsic expectations that people brought to caring work defined as 'anticipatory socialisation' they were less important than their work experiences in the personal service professional culture.[15] Halmos argued that the determinants of the values of personal service orientation were to be found in the socialising influence of the personal service professional culture. The personal service professional would occupy a specific role within a particular personal service professional culture and through this role, the professional would assimilate the cultural values into his role system.[16]

Halmos placed considerable emphasis upon the relationship between the occupation of a personal service role and the development of the personality. He argued,

> The very notion of personality may be defined as a system of roles learnt by the organism .... the organism is mere potentiality which grows into a personality through the process of learning to play roles and by the acquisition of a collection or system of roles, any one of which it is capable of assuming.[17]

Halmos also argued that certain roles were more important than others: "an individual's role organisation may become dominated by a single central role - a cardinal role of the personality". He stressed that the personal service professional would learn that his or her professional role would become the central role, and this would be a dominant influence in shaping the personality of the individual.[18]

Halmos maintained that the personal service professional would gradually internalise the norms and values of the particular work culture and he expressed this particular point: "The power of the role over the person is great and lasting enough to bring about changes in the personality or in certain attitudes imprinted by other roles previously shaped".[19]

Whilst Halmos recognised that there were specific personal service professional cultures, the core values of these cultures had their roots in the values of Christian, Hippocratic and Humanist leadership and thought. He then argued that the fusion of the traditional values that had influenced the values of the medical and legal professions with the more recently formed values of the new counselling professionals, with its counselling ideology, would create a personal service professional culture.[20]

Halmos believed that the 'counselling ideology' was based on such values as sympathy, concern for people and affection for them. This

ideology had been developed by such caring groups, in industrial societies, as social workers and counsellors whose role was concerned with helping people in need. The caring workers depended a great deal upon the developments that had taken place in the 19th and 20th centuries in the social sciences.[21] He argued that the values of the 'counselling ideology' were now being merged with the values of the older professions, such as medicine, law and the church to produce a 'personal service ideology.[22] He maintained that the personal service ideology was based on a system of beliefs and values that provided a more positive solution to meet human needs and overcome alientation in mass societies, than the solutions offered by political and religious ideologies.

The 'personal service ideology' was perceived by Halmos as a major social influence which would improve the human condition in industrial mass societies. He illustrated the nature of this influence by describing the way in which personal service values were influencing industrial work-cultures, through the development of personnel management departments and the increasing emphasis that industrialists placed upon human relations.[23] According to Halmos the personal service professionals could justifiably argue that their "services were for the good of the client and of society". He stressed that the number of personal service professional groups were increasing in modern indistrial societies and this was also the case with their aides, and these groups represented a strong force for social change.[24]

Other sociologists have stressed the positive qualities of personal service professionals, although they have not made such strong claims about their importance as agents of social change. Georgepoulous and

Mann stressed the importance of the values and norms of hospital sub-cultures.[25] They described the hospital as;

> an extremely complex social organisation that differs from business and other large scale organisations on a number of important characteristics. The main distinguishing features of the hospital's objectives compared to industry is that the main objective of the hospital is to render personalised service rather than the manufacture of some uniform material object.[26]

These two sociologists also stressed the degree of mutual cooperation between the occupational groups in hospitals,

> Hospitals are primarily concerned with the cure, care and treatment of individual patients and not with producing goods and consumer services. In order to achieve these goals, the hospital as an organisation must use modern techniques and provide the structural arrangements to enable people to coordinate their energies to achieve these goals.

Georgepoulous and Mann also stressed the significance of meaningful work for hospital workers: "Most members give unstintingly of their energies to the tasks assigned to them". They see the hospital as a non profitable organisation.[27] They also supported the views of Halmos[28] when they described the leadership qualities of such personal service professionals as doctors and nurses: "Many doctors and nurses look upon their profession as a sacred calling".

In a similar vein to Halmos[29], Georgepoulous and Mann[30] gave examples of the dominant norms of the hospital sub-culture: "giving good food and attention to patients, devotion to duty, loyalty, self-lessness, altruism, hard work and discipline".

It is evident that the hospital is a caring organisation which has been influenced by the medical professionals, who are recognised

as the most powerful and influential of the personal service professionals groups employed there, according to the findings of such sociologists as Waitzkin and Waterman[31] and by Willcocks.[32]

It might be argued that the norms referred to by Georgopoulous and Mann[33] should be described as ideals. They would, however, merit consideration by supporters of Halmos that they represent standards that should inspire personal service workers in hospitals.

Another sociologist who tended to support Halmos was Strauss[36] who wrote about a psychiatric hospital he investigated, "The hospital was a professional locale where persons drawn from different professions came together to carry out their respective purposes". Strauss made the point, "Personnel in our hospital share a single vaguely ambiguous goal. The goal is to return patients to the outside world in better shape".[37] It is clear that Strauss perceives the hospital as meaningful place of work which induces a strong sense of commitment to a worthwhile human goal. But he recognised that there was scope for normative conflict: "Although personnel may disagree to the point of apoplexy about how to implement patients getting better they do share a common institutional value".

Strauss made a very significant point when he described the nature of the close cooperation in the hospital. "The hospital is unique in the close cooperation which is requested between different grades of staff with very different educational backgrounds".[38] This point is of particular relevance to the argument presented by Halmos about the importance of professional leadership for aides and ancillaries that worked with personal service professionals.[39]

The views that I have commented on are, in my view, typical of a number of views that refer to the positive consensual nature of the hospital organisation, but there are other views that present a less favourable perspective of hospital organisations and their goals.

Willcocks, in his study of the development of the National Health Service (NHS), described the growth of professional associations in the service and demonstrated how these emphasised the distinctive nature of their role in their negotiating stance. He referred to the bargaining element in professionalism and underlined the nature of the sectional interests of professional groups.[40]

We are also aware of the opposition of the medical profession to the aspirations of other professional groups to practice certain aspects of medicine, wuch as osteopaths in the U.K. or chiropractors in the U.S.A. The opposition might well be justified but it does suggest that issues of vested interest and material gain are often argued under the guise of protecting the patient or guarding the values of the professional culture.

Other sociologists who have studied the role of the professions also question the professional ethics advanced by personal service professionals. Wright Mills[41] made this critical comment in his book 'White Collar', about the medical profession in the U.S.A.

> The professional ethics in which this interest group clothes its business drive is an obsolete mythology but it has been of great use to those who would adapt themselves to predatory ways, attempting to close the ranks and freeze the inequality of status among physicians and the inequality of medical care among the population at large.[41]

Wright Mills argued that the role of the medical professional had

changed in the U.S.A. He perceived a shift from the individual physician or the group practice physicians to the hospital physician, and argued that the most influential hospital physicians who supported a large scale medical technology were "a new sort of entrepreneur".[42] This view presented by Wright Mills is referred to because it presents a perspective of a traditional personal service professional group that is significantly different from the view presented by Halmos and it raises some questions that are relevant to understanding the ideology or ideologies of personal service professionals.[43]

Halmos argued that the influence of personal service professionals should be seen as a major force of social change. The values and norms of a personal service professional culture will gradually shape the social institutions in society through individuals in all walks of life accepting the values of the personal service culture. These values will be assimilated through the personalities of individuals who fulfil specific social roles.

The pace setters of social change are the personal service professionals who become highly involved in a personal service culture that is primarily concerned with humanistic objectives. Halmos believed that his view of social change was in accord with the needs of people who had become increasingly alienated from political solutions.[45]

Halmos argued that the growing influence in the application of social science knowledge to the solution of human relations problems in industry exemplified the way in which knowledge, skills and values nurtured in the personal service culture would penetrate industrial organisations.[46]

The main impetus for social change would come from the middle classes in capitalist and communist societies, who would be led by an elite group of personal service professionals. The enlarged middle class of these industrial societies would contain a firm core of personal service professionals who would emerge as the most influential of the various professional and occupational groups.

The socialising experience of the enlarged middle class would nurture and shape the structure of society which would move away from the social systems of capitalism and communism, whilst retaining certain of their cultural characteristics.

The cultural stress that capitalist societies placed upon personal achievement would be retained but it would be diverted from achievement in the pursuit of materialistic success to achievement in rendering a personal service. Halmos argued that both capitalist and communist societies "are obliged to fit their social system into a technologically given framework which tends to be the same for all systems whether communist or capitalist".[47] In both types of social political systems the main cultural drive will be from the personal service professionals. They will become the models of esteemed social behaviour.[47]

Halmos recognised that there would be pluralistic conflicts in society; there would also be pluralistic conflicts between the personal service professionals and within them but, out of this conflict, there would emerge a strong coherent personal service ideology that would become the basis for far-reaching social change.[48]

In view of the fact that Halmos[49] recognised the need for his hypotheses to be substantiated by empirical research, it is reasonable

to suggest that one of the ideal caring situations for testing such hypotheses would be to examine the nature of the influence of a particular personal service culture that has been shaped by medical and nursing groups, two of the most established and traditional professional groups. Such a situation should exist in hospital organisations.

If we also focus upon one of the most dominant and crucial centres of the hospital personal service professional culture, where its values and norms have been refined and, according to Halmos, 'orientated' towards the highest standards of personal care, then few would, I am sure, disagree with the selection of the operating departments of hospitals as models of excellence for personal service professional cultures.[50]

The established leadership in these departments would, in the context of the Halmos hypotheses, be the consultants, surgeons and anaesthetists and in spite of the various definitions of a profession, most people familiar with hospital work would consider senior theatre nurses to play a leadership role.[51] All of the trained nurses working in this department should be an important reference group for ancillaries like theatre assistants who want to establish some degree of professional identity defined by Halmos. I believe that the empirical research that I am interested in provides the opportunity to test the validity of some of the hypotheses that he was advancing.[52]

Firstly, I can test the hypothesis that personal service workers who play a supportive role to personal service professionals should develop a personal service orientation to their work. Secondly, I

can test the hypothesis that one of the determinants of the development of this orientation among non professionals (such as ancillaries) is the support and tutelage provided by the key personal service professionals for the ancillaries who work with them.

The importance of the socialising influence of key reference groups has been recognised by Shibutani. He made the point that people who represent key reference groups in organisational situations have an important influence in socialising the subordinate groups that support them.[53]

The ancillary workers that I will be investigating in this research come into contact with nurses more frequently than they do with other professional groups. There is, however, one group of ancillary workers who also have very close working relationships with consultants and other doctors. These are the theatre assistants who, in the context of the Halmos hypotheses, would be regarded as highly involved in the specific personal service professional culture of the operating department of the hospital.[54]

The plan of this thesis is as follows. In chapter one I will discuss some of the findings of the published literature that helps us to understand the main reasons why people decided to enter certain occupations. I will pay particular attention to the work of Goldthorpe *et al.*[55] which explained in some depth the importance of the expectations that people brought to their work as a means of understanding patterns of work motivation.

I will be particularly interested in comparing the expectations of industrial workers with those employed in the personal service occupations. I will consider the extent to which there is a variation in the groups in respect of their intrinsic expectations.

In chapter two, I will discuss some of the published findings and other documentary evidence that was concerned with the nature of the intrinsic satisfactions of two categories of personal service workers. Firstly, I will focus upon the literature relating to nurses, an occupational group with a strong degree of personal service commitment. Secondly, I will focus upon the literature relating to hospital aides and ancillaries.

In this chapter I intend to establish the extent to which the pattern of work involvement of these personal service occupational groups is in accord with the pattern of intrinsic involvement in caring work, described by Halmos as 'personal service orientation'.[56] I will also be interested in establishing the extent to which people in personal service work roles differ from people in industrial work roles in respect of their form of intrinsic involvement in work.

Having discussed these findings I will proceed to discuss my

empirical research into the role of the hospital ancillary worker. I will then examine the ancillary workers' involvement in work and the degree to which they were intrinsically involved in their work. I hope to demonstrate that the components of this form of intrinsic involvement are similar to the components of the first value of personal service orientation.

In this chapter I will also define the second value of personal service orientation 'concerned empathy'. I will try to identify the ancillaries who expressed one or more of these values. In chapters four and five, I will examine the degree to which ancillaries expressed the third value which I will refer to as occupational integrity. If these ancillaries perceived that they had the support of nursing staff, they should have been in a position to demonstrate to patients and other helpers in the hospital, that they were maximising their role performance with confidence, which provided them with the type of integrity referred to in the third value of personal service orientation.

In chapter four, I will examine the relationships that ancillaries established with medical and nursing groups. I will be particularly interested in the support, encouragement and tutelage that the ancillaries considered they received from these personal service professionals. Will this support be in accord with the type of support envisaged by Halmos?[57]

In chapter five, I will focus upon the degree of role strain that the ancillaries experienced in their work. It is reasonable to assume that ancillaries who worked in a supportive work environment of the

type described by Halmos[58] should not experience a high degree of role strain.

In these three chapters, I will be testing the hypotheses postulated by Halmos[59] that ancillaries who work with and for personal service professionals should become personal service orientated. In the context of this study, this should apply to the theatre assistants who work more closely with medical and nursing groups than the other ancillaries referred to in this study. But, in view of the fact that most of the ancillaries worked with nurses, then relationships with nurses should be the crucial one for measuring supportive relationships within the personal service professional culture.

The data relating to the three values of personal service orientation will be examined and analysed in chapters three, four and five. At the end of chapter five, it should be possible to devise a scale which will enable the degree of personal service orientation expressed by ancillaries in their work to be measured. The components of personal service orientation are broadly in accord with those defined by Halmos; with some modification to take into account the manual characteristics of ancillary occupations in the NHS.[60]

In chapter six, I will focus upon the extrinsic aspects of the ancillaries aspirations. I will consider the nature of their economic and social aspirations. I will also examine the way in which they endeavoured to improve their material rewards and occupational status. The discussion of the ancillaries aspirations is also relevant to the Halmos view of the personal service culture.[61] It will be interesting to examine the influence which non-professional manual workers intro-

duced into the sub-culture of hospitals. How influential were they in introducing new norms and values?

In chapter seven, I will try to draw some firm conclusions from my empirical research. Firstly, I hope to come to some firm conclusions about the validity of the hypotheses advanced by Halmos.[62] Secondly, I will consider some of the more practical implications that should be of interest to all who are involved in the work of hospital ancillaries.

Other concepts of work orientation

I have described the way in which Halmos[63] defines orientation when I referred to his notion of personal service professionals directing their role performance towards achieving the ideal standards prescribed in the personal service professional culture. Other sociologists have also referred to orientations to work when discussing work motivation.

Fox argues that there are two broad values that merit consideration in a discussion concerned with orientations to work. The first value is concerned with the doctrine of work, and maintains that work "ought to be a central integrating principle of man's individual and social being, offering opportunities of choice, decision and responsibility".[64]

The second value placed on work is one that accepts the fact that there are limited opportunities for work to be intrinsically satisfying and that satisfaction should be derived from external factors such as financial rewards or the job security.

It is evident that the first value referred to by Fox places great

weight upon the intrinsic satisfactions experienced in work, these satisfactions are important because they contribute to the personal development of the individual worker.[65] This work experience nurtures the emotional gratifications that Herzberg[66] describes as the 'satisfiers', such as the sense of achievement or the sense of responsibility. These intrinsic satisfactions are also recongised by Maslow[67] when he refers to meeting the needs of the ego through accomplishments in work.

It is evident that the intrinsic considerations referred to by Herzberg[68] and Maslow[69] have much in common with the three values of personal service orientation described by Halmos.[70] It is reasonable to argue that the concept of personal service orientation defined by Halmos should be regarded as a variant form of intrinsic involvement in work.[71]

Extrinsic and intrinsic expectations

Let us now consider the importance of the instrumental orientations that Goldthorpe *et al.* attached so much importance to, in their industrial studies in the Luton industries, when they established that most workers valued material rewards.[72] Goldthorpe *et al.* defined these workers as being predominantly instrumentally orientated to their work.[73] Their work was meaningful to the workers because it was instrumental in enabling them to obtain the income that they needed or, to quote Goldthorpe *et al.*, "The primary meaning of work is, as a means to an end or ends external to the work situation; that is, work is regarded as a means of acquiring the income necessary to support a valued way of life".[74] The instrumentally orientated workers are

mainly concerned with maximising their economic returns with the minimum degree of effort. They are attached to their job and their employer as long as the economic rewards are considered to be satisfactory. They consider their work in 'calculative terms': it is not "an activity valued for itself, the ego involvement in their jobs - in either the narrower or wider sense of the term - is weak".

Goldthorpe *et al.*[75] argued that the instrumentally orientated workers do not consider their jobs to be a central part of their lives. Work for them is not a source of "emotionally significant experiences or social relationships: it is not a source of self realisation".[75]

Goldthorpe *et al.* found that workers were aware of the nature of the intrinsic satisfactions that could be derived from certain aspects of their job. They were, however, willing to forego these satisfactions as long as they could obtain monetary rewards that enabled them to maintain the style of life that they considered to be appropriate for themselves and their families.[76]

Goldthorpe *et al.* maintain that the expectations that many workers bring to their jobs are shaped by cultural factors outside the industrial organisation. These expectations reflect the needs of workers that are determined by wider social and cultural considerations, which influence them to achieve a standard of living related to a life style geared to obtaining a share of the material prosperity offered in a consumer orientated society.[77]

Goldthorpe *et al.*[78] recognise the importance of other forms of work orientation which they describe as 'bureaucratic' and 'solidaristic'.

Whilst the workers in both of these categories want instrumental rewards, they consider other features of the job to be more important.

The bureaucratically orientated workers value the career opportunities offered by some organisations and the status conferred by the job. They consider that their employers will respect the service they provide as workers, and this should bind them together.

The solidaristic workers value their jobs because of the strong social relationships they experience in it. Some workers value a close relationship with their employer: workers in small firms. Others, such as coal minters, value their relationships with their workmates.

There are, according to Goldthorpe *et al.* three essential differences between the instrumentally orientated workers and the other two types. Firstly, the instrumentally orientated workers base their relationships on a calculative basis, whilst the other two categories recognise some degree of moral obligation either to their employers or to the work group.

The second difference is that the instrumentally orientated workers have no ego involving experiences in their work, and work is not a central life interest. This is not the case with the bureaucratic and solidaristic categories of workers.

The third essential difference between these categories of workers is that among the instrumentally orientated workers, there is a sharp dichotomy between work and non work activities, for the other two there is not a sharp distinction.[79]

Goldthorpe *et al.* recognise that all of these orientations influence the value that people place upon their jobs. They found that some people placed more emphasis upon the material rewards provided by their jobs. These were defined as instrumentally orientated workers; they were willing to work as long as the income was satisfactory. The instrumentally orientated workers were less emotionally involved in their work than the bureaucratically orientated and solidaristically orientated workers.[80]

Goldthorpe *et al.* are predominantly concerned with countering the influence of those sociologists and psychologists who view problems of work motivation as reflections of the individual needs of workers (Herzberg[82], Maslow[83]) or the view of Woodward[84] that the technology of work is the most important determinant of motivation.

Other sociologists have argued that Goldthorpe *et al.* place too much weight upon the reasons why people chose a job and not enough consideration is given to the way in which work experiences shape people's expectations. Brown[86], Daniel[87] argue that work experiences can modify the expectations that people bring to their work. A worker might enter a job for instrumental reasons but will remain in it because of its intrinsic satisfaction.

Beynon and Blackburn[88], in their study of work attitudes in a biscuit factory, found that men placed more emphasis on the material benefits obtained in work, and this encouraged them to become more attached to it than the women employed there. They suggest that women tend to see work as a source of income and place more weight than men, upon friendship and social ties in work. It may well be the case that

women will take a job because they see it as a means of supplementing the family income, but the friendships that they develop in work become more important. This tends to support the views of Brown[89], Daniel[90] and Goldthorpe *et al.*[91]

Fox, in his study of work orientation, made this point: "The higher the individuals position in the occupational hierarchy, the greater the evidence, on the whole of concern with intrinsic values in work",[92] He also stressed that people in middle class occupations had far greater opportunities for "instrinsic rewards, in terms of job interest, judgement, discretion, challenge, responsibility and control".[93] It is interesting to note that the aspects of work referred to by Fox are similar to the component of the first value of personal service orientation as defined by Halmos.

Fox's view about the work values of middle class workers is supported by Morse and Weiss[96] who compared the work values of people in professional and managerial occupations with those held by manual workers.[96] They found that those in middle class occupations had more interesting and prestigious and autonomous jobs than those in working class occupations. They argue that middle class workers consider their jobs as being of central importance in their lives, in contrast to those in manual jobs who, in the main, adjust to their job, or resign themselves to it.[96] Morse and Weiss also refer to the important socialising influence of parents and relatives who work in intrinsically satisfying jobs, in nurturing the work expectations of the younger members of the family. The young, they argue, learn to value the intrinsic satisfactions provided by certain occupations.[97]

Fox[98], Morse and Weiss[99], make the point that middle class children

also learn to appreciate the discipline and training needed for the intrinsically rewarding occupations. This type of socialisation is not confined to middle class families. Marsh and Willcocks, in their study of young people entering nursing, found that families with hospital experience had a positive influence in guiding girls into a nursing job.[100]

It is also worth considering the findings of Daniel who investigated the expectations of manual workers in a petro-chemical plant and in a nylon process plant.[101] He established that whilst the manual workers in these plants were mainly interested in extrinsic considerations such as wages, they became aware of the importance of intrinsic considerations as a result of their experiences in their work.[102]

Daniel found that when semi-skilled workers in a nylon plant were involved in negotiating productivity deals with their managers, their main objectives were improved wages and working conditions. But, after the productivity deals were implemented they found that some of the consequences of the new working arrangements were the opportunities provided for work that was more interesting.[103]

Daniel makes the point that whilst the appreciation of intrinsic work opportunities cannot be seen as a substitute for the extrinsic rewards that workers value, and which they cling to, they can learn the value of intrinsic work activities. Although he argues that workers can value both extrinsic and intrinsic rewards, he did, however, appreciate that the economic circumstances of these workers compel them to value the extrinsic rewards more than the intrinsic ones.[104]

Dubin, in an extensive study of manual workers in industrial occupations in the U.S.A. who were employed in the manufacturing industries, found that work was not their "central life interest"; it was not the source for their intrinsic satisfactions.[105] Dubin established that the workers sought their intrinsic satisfactions in their social activities in the community.[106]

It is evident that most of the studies that I have referred to in this chapter indicate that most manual workers value their work for the extrinsic rewards they derive from it. In this sense they can be described as being instrumentally orientated. It will be interesting to consider the value of work orientation of managerial and professional workers to see if they differ in a significant way from the manual workers.

Personal Service Professionals

It has been argued that those who enter managerial and professional occupations can enjoy the benefits of extrinsic and intrinsic rewards (Fox).[107] Sociologists who have studied the personal service professions have placed varying degrees of emphasis upon the reasons why professionals chose such work and why they remain in it. Halmos[108] stresses the importance of professional values and the intrinsic satisfactions derived from caring work. Hall[109] argues that the work of professionals entails certain social responsibilities and obligations which he defines as "attitudinal attributes", such as a "belief in the service to the public, a sense of calling to the field". He also recognises the attraction of professional work because it provides opportunities for autonomy in work.

Wilensky[110] argues, as Halmos[111] does, that the medical professionals are obliged to conform to the norms of a service ideal. He takes the view that those who enter medicine are predominantly motivated by a desire to provide a service. Wright Mills[112] took a more cynical view of the motivations of medicals and argued that the medicals in the U.S.A. were primarily concerned with "generating income". Siebert[113] also stresses the importance of monetary considerations as an inducement that attracts recruits to the medical profession. Tutmuss[114], whilst recognising the commitment to patient care of many doctors working in conditions of poverty in the pre-war years of the thirties, expressed concern about the increasing emphasis they were placing on monetary reasons.

Sherlock and Cohen[115], in their study of dentists in the U.S.A. recognised that "service ideals, prestige and income" were key influences upon occupational choice, but there was considerable variation in the importance they attached to these considerations. Quinney[116], in a study of pharmacists in the U.S.A., came to similar conclusions.

Simpson[117] argues "that without exception our nurses stated that the main reason for choosing nursing as a career had been a wish to serve suffering people", although she recognised that the reality of nursing could be stressful. Aitschul[118] argues that nurses may have chosen nursing because of its ideal image which they wanted to be identified with, but "the reality of nursing convinces them that such an image of themselves could not be sustained". This sociologist is of the opinion that motivation to be a nurse is the most important characteristic of the successful nurse but there are also important

structural considerations of importance, particularly the long period of training for the registered nurses.[118]

Krause noted the importance of structural factors such as the family and the level of education, as determinants of occupational choice. He expressed the view that the lower the socio-economic level of the worker, the more restricted they were in choosing their occupation and the fewer the opportunities resulting from this choice. The length of training and the accompanying costs incurred enabled a higher proportion of recruits to the professions to come from middle class homes.[119]

McGuire found that education influenced to a considerable degree the choice of nursing as a career. The girls who became State Registered Nurses (three years of training) came mainly from professional, or non manual homes.[120] It is interesting to note that the Briggs Report showed that there was a relationship between the degree of training that nurses received and their fathers' occupation, over 52% of the registered nurses coming from professional non-manual, homes, with 12% from semi skilled, manual homes. A lower proportion of the enrolled nurses (27%) and auxiliary nurses (22%) came from professional non-manual homes.

Marsh and Willcocks[121], in their study of nurse recruitment in Mansfield, a predominantly working-class community town, stressed the importance of the family as a source of guidance. These sociologists established that 58% of the girls investigated in their study became nurses, considered that they had received positive encouragement to take up nursing from their families. They also noted the important

influence of those families that contained people with some experience of nursing work.[121]

In a study of young girls who had left school in Mansfield, these sociologists found that the girls varied in their perception of a nursing occupation. They found that, whilst the majority of girls considered nursing as a career with its opportunities for improving job prospects through training, a substantial minority were interested in nursing as a vocation with its emphasis upon dedication and the ability to serve.

This study also brought out the social influences upon the perception of nursing outlined by the girls. It was established that the girls who had been to a grammar school were more interested in the vocational aspects of nursing than the career aspects, whilst the girls from the secondary modern schools placed more amphasis upon career opportunities.

Mayer[122], in a study of social workers, found that those who entered social work from middle class homes placed more emphasis upon the vocational caring and helping aspects of social work, whilst those who came from manual workers' homes stressed the career opportunities in social work.

These studies indicate the importance of such structural factors as education, parental occupation and social class as determinants of occupational choice, and as factors that shape the work expectations of those who enter caring professions and occupations.[122]

It is also interesting to consider the variation that can exist among manual workers in respect of the support and guidance they provide

for their children entering work for the first time. Carter, in a study of school leavers in Sheffield, found that some homes were more supportive than others. He also established that the children of skilled workers had higher work expectations than those from semi-skilled and unskilled workers' homes.[123]

This variation within the homes of manual workers was also established by Willmott in a study of young workers in East London. He found that the school-leavers from skilled workers' homes had better opportunities for white-collar and skilled jobs than those from the homes of semi- and unskilled workers' homes.[124]

Aides and ancillaries

Research into the work expectations of hospital ancillaries indicates that they were mainly interested in satisfying extrinsic considerations when choosing a hospital job. The N.B.P.I. 169 report of 1971, which was based on a wide ranging study of hospital ancillaries, found that male ancillaries were primarily interested in a hospital job because of the security it offered. Other important considerations were that it was the only job available, or because they believed they could cope with the physical demands of hospital work. They found that 12% of the males and 3% of the females chose their job for health reasons, and that 12% of the sample had left their previous job because of ill health. The report also noted that the N.H.S. ancillary work force had a high proportion of disabled workers.

Evans and Morgan[125] found that many porters chose a hospital job because they believed it to be less physically demanding. They

also noted that one in five of their sample chose hospital work because of ill health. A study of the Morbidity of Ambulance Rates among ambulance workers by Durham County Council in 1972 found that a significant proportion were recruited from industrial occupations which they found to be hard and physically demanding. They also established that a significant proportion of ambulance workers did not enjoy the best of health when they entered ambulance work.*

Williams *et al*[126], in a study of two London hospitals, noted that many ancillaries chose a hospital job because they were dissatisfied with their previous job or because they had become redundant. They also noted that a substantial proportion of ancillaries were immigrants, particularly among the catering and domestic staff. The N.B.P.I. 169 report indicated that the main consideration for females was that hospital work was convenient for meeting domestic arrangements and that it was a job near home. Coghill[127] also found that these considerations were particularly important for the married women with families. Woodward[128] also drew similar conclusions and stressed the convenience factor as a major consideration for young mothers.

Whilst these studies clearly demonstrate that instrumental and extrinsic considerations were the most important determinants of occupational choice, they also indicated that intrinsic considerations were of some importance. The N.B.P.I. 169 report mentioned the attraction of hospital work to male and female ancillaries, who

* Durham County Council, Health Services Committee 1972, on The Mortality and Morbidity of Ambulance Workers

found it to be satisfying and worthwhile.

Coghill[129] found that about half of the domestics he surveyed in a Middlesex hospital suggested that they preferred hospital work to other types of work and that they considered it to be an essential service which they wanted to be associated with. Woodward[130] also referred to the importance that domestics attached to interesting work which was of service to the community.

There is also some evidence that the solidaristic considerations that Goldthorpe *et al.*[131] referred to were of some importance for the female ancillaries and Williams *et al.*[132] found that an important reason for domestics choosing a hospital job was because they had relatives and friends working there. Jeffries[133], in a study of domestics in a large South Wales hospital, stressed the supportive nature of friends, relatives and neighbours in this hospital as an important attraction of hospital work.

It is quite evident that the influence of the family and their work experiences have some bearing upon the work expectations and aspirations of young people. These experiences, according to Marsh and Willcocks[134], can have a positive or negative influence upon the choice that school leavers make when entering the world of work.

Summary

In this chapter, I discussed the expectations and aspirations of various groups of workers. I outlined the importance that sociologists such as Goldthorpe *et al.*[135] and Fox[136] attached to these work expectations as a means of understanding the meaning

of work to people in varying occupations.

The findings that I discussed in this chapter indicated that social and economic factors are important determinants of occupational choice. The findings also suggested that workers in the personal service professions and those employed in managerial, white collar and skilled occupations in industry were in a better position to obtain work that was intrinsically satisfying than those workers in semi-skilled and unskilled personal service and industrial occupations. The unskilled and semi-skilled workers tended to come from more disadvantaged circumstances than the other categories of workers, they had lower educational qualifications and this was reflected in their lower work aspirations. If we relate occupational aspirations to the father's occupation, we find that young people from middle class homes had better opportunities for choosing interesting and satisfying jobs with good extrinsic rewards than those from manual workers' homes.

Even in nursing, according to the Briggs Report of 1973, we found that SRNs were predominantly drawn from middle class and skilled manual workers' homes, whilst auxiliary nurses were predominantly from semi-skilled and unskilled workers' homes. It is, however, significant that the SRNs, the higher grade nurses, earn a much lower income than doctors. Whilst doctors are predominantly from middle class backgrounds, they are also in a male dominated profession, whilst nurses are in a traditionally female profession with a long history of exploitation under the guise of vocational dedication.

In spite of low financial rewards, many nurses have been attracted to nursing because of the intrinsic satisfactions experienced in this work. The commitment of nurses to patient care and the close relationships which they have with medical groups, entitles them to be regarded as the type of personal service profession that Halmos considered to be so important as a socialising influence in the personal service professional culture.[137]

In the next chapter I will examine the extent to which nurses were intrinsically involved in their work. I will also consider the extent to which hospital aides and ancillaries (two occupational groups which play a vital role in supporting nurses) experience intrinsic involvement in their work. It will be interesting to consider the extent to which the pattern of work involvement of nurses, aides and ancillaries resembles the pattern of caring work that Halmos described as 'personal service orientation'.

CHAPTER TWO

THE ROLE OF NURSES, AIDES AND ANCILLARIES

Intrinsic involvement in nursing work

In this chapter I will examine the published findings of those sociologists who have studied the pattern of work motivation of nurses, nursing aides and hospital ancillary workers. We noted in the preceding chapter that nurses in the main expressed strong intrinsic expectations in their work. In this chapter I will consider the extent to which nurses, aides and ancillaries experience some form of intrinsic involvement in their work. I will also consider the extent to which nurses express the form of involvement that Halmos referred to in his three values of personal service orientation.[1]

The role of the nurse is of particular relevance to the concept of personal service orientation because nurses are more frequently involved with nursing aides and ancillaries than any of the other personal service professional groups in hospitals. In this respect, nurses represent a key reference group for those ancillaries who seek fulfilment in their caring work and in particular for those ancillaries who have para-professional aspirations.

Whilst there might be some reservations about regarding all nurses as personal service professionals, most sociologists would, I am sure, agree that the degree and diploma nurses in the U.S.A. and the SRNs in the U.K. should be defined as professionals. It is also reasonable, in the context of a study concerned with the relationship between nurses, nursing aides and ancillaries, that the SRNs could also

be considered to have professional standards and values.

Altschul[2] and Strauss[3] found that nurses were intrinsically involved in the nursing role, which they found to be meaningful and worthwhile. Burz[4] and Handschu[5] came to similar conclusions in their studies of nursing aides. Kramer[6] and McLoskey[7] found that nurses could experience self realisation and personal development in nursing. These findings suggest that the components referred to by these sociologists have a great deal in common with those referred to by Halmos[8]. The findings of these sociologists tend to support Halmos when we focus upon the opportunities for personal development in caring work.[9]

It is, however, important to note that industrial sociologists, who have studied patterns of motivation in industrial work, have stressed the need for workers to use and develop their personal resources in their work. Blauner[10] and Susman[11] placed considerable stress upon this form of intrinsic involvement, as a means of preventing industrial workers from being alienated. The components of intrinsic involvement that they referred to, such as meaningful work that made use of a worker's interests and aptitudes, are relevant to industrial workers as well as those in personal service occupations.

Blauner[12] and Susman[13] also stressed the importance of another component of intrinsic involvement that Halmos[14], in his definition of the first value of personal service orientation, did not refer to. This component is workplace participation, which refers to the ability of workers to exercise some degree of control or influence over their immediate work environment, such as the workshop, print room or

laboratory.

Although Halmos[15] does not refer to the component of workplace participation, other sociologists, particularly those who have studied the nurse's role, have considered this component to be of considerable importance.[15]

Pearlin[16] argued that nurses would be alienated on the dimension of powerlessness if they were not able to influence the decisions that their supervisors made on matters that the nurses were interested in. Traile, in a study of role strain and alienation in nursing, made the point that nurses could experience a high degree of intrinsic satisfaction from helping patients, but they could also experience a feeling of alienation if they could not influence decisions that directly concerned them.[17]

Hespe and Wall[18] also stressed the importance of workplace participation among nurses. In a study of three categories of nurses, SRNs, SENs and nursing auxiliaries in two hospital groups, it was established that nurses wanted varying degrees of participatory involvement, ranging from ward matters described as local issues, to long term matters dealing with such items as purchasing equipment. They also found that the more professional nurses, (SRNs and SENs) had stronger aspirations than the auxiliaries on these matters.[18]

Coghill[19] also referred to the importance of workplace participation for nurses, medical and ancilliaries, on a ward basis and his report on the way in which he brought workers from all grades to discuss ward matters, including problems of patient care, represents an ambitious attempt to develop a team approach based on participatory

methods.

It is evident from the published studies that most nurses expressed all of the components of the first value of personal service orientation as defined by Halmos[20]. But the findings also placed considerable emphasis upon the importance of workplace participation as a component of intrinsic involvement in work and this, I believe, is very relevant to the nurse's role. We now need to consider the degree to which other sociologists support Halmos about the importance of the second value of personal service orientation, 'concerned empathy'.[21]

It is important to recognise that empathy, as a value in nursing, is deeply rooted in the nursing culture often expressed as 'tender loving care'. Yet there is some evidence that, whilst it is a strong element of current nursing ideology, the professional nurse has become less involved in the face to face or bedside relationships with the patients and more involved with administrative and technical tasks.

Empathising with patients

Some evidence concerning the degree to which professional and non-professional nurses establish empathic relationships with patients is available from the literature that relates to the work orientation of nurses, and also from the literature concerning role strain.

Anderson, in her study of nurses, demonstrated how some nurses derived most of their work satisfaction and intrinsic challenge from the relationships that they established with patients; these were described as patient orientated nurses. Other nurses derived their

satisfactions from the technical tasks they were engaged in and these were described as task-orientated nurses.[22] Anderson recognised that both groups of nurses could be involved in an intrinsic way, but empathic relationships should not be regarded as the sole test of concern for the patient.[23] Halmos argued that caring workers should know their clients very well and have a deep insight into their emotional needs.[24] Anderson recognised that one can help patients effectively through technical competence and skill, and implied that one is not always able to demonstrate on a personal basis the nature of the help provided.[25]

This sociologist also appreciated that even among the patient orientated nurses, there were degrees to which they wanted a personal relationship with the patient. It has been recognised by others that nursing, although satisfying, can be stressful and that not everyone possesses the tough and tender personal qualities for nursing in critical and stressful situations. This point was made by Tomlin[26], a consultant surgeon responsible for intensive care in a Birmingham hospital, when he stressed the need for special working conditions for intensive care nurses.[26]

Bramner[27] would argue that the type of relationship described by Tomlin[28] demands the empathic qualities of warmth and caring. Bramner[29] argued that helping people demands a certain degree of skill in conveying a feeling of closeness, affection and caring concern for the helpee, without becoming involved in "emotional entanglements, offensive forwardness or threat of seduction".[29]

This view of the helping role expressed by Bramner[30] is very relevant to hospital workers.[30] It is a view that is in accord with

the type of support which was appreciated by Central Health Services Council when they reported in 1976 about the problems of patient care in hospitals. This report stressed the importance of ancillary workers relating to the needs of the patients within the framework of a caring team of medicals, nursing and para-medical professionals. Within such a team the ancillary workers should at least provide some degree of warmth and, in certain situations, they might be able to develop a caring relationship with patients experiencing a crisis in their lives when receiving hospital care.

Sociologists such as Pearlin and Rosenburg[31] and Evans[32] have recognised that patients, particularly those from the lower income groups, were more inclined to be friendly and open in their relationships with nursing aides than they were with senior nurses and medical staff. Evans, in his study of tubercolosis patients, made the point that highly stratified nursing structures could inhibit relationships between nurses and patients and that some patients were more inclined to be alienated in highly statified wards than in other wards.[33]

Schmitt, in a study of nurse patient relationships, outlined that the many demands on professional nurses often prevented them from empathising with patients and that this aspect of the nursing role was increasingly being undertaken by nursing aides.[34]

It is reasonable to argue the case that if nursing aides and some ancillaries are cultivating this aspect of the traditional nursing role, they should receive some degree of training for this work. It should also be appreciated that if empathising with patients becomes an established part of the aides' role they will want to be recognised

for it. This need for recognition was stressed by Burz.[35]

When we consider the relevance of 'concerned empathy' which Halmos[36] refers to as the second value of personal service orientation, we need to consider the views of those sociologists and psychologists who recognise that the relationships between helpers and helpees need not be as close as Halmos suggested.[37]

Bramner argues that certain people have personal qualities which can be harnessed and cultivated to help people in need. He also recognises that there are degrees of empathy and these are based on two forms of emotional response.[38] The first form of emotional response is defined by Bramner as 'warmth', which he considers to be a "condition of friendliness and consideration manifested by smiling, eye contact and non verbal attending behaviour".[39] Most people would agree that this is a desirable quality for all helpers and the expression of warmth is appreciated by all helpees. It is reasonable to argue that patients and relatives will appreciate the expression of warmth from all hospital workers that come into contact with them. The second form of emotional response defined by Bramner[40] is 'caring' and he made this point: "caring is a term closely related to warmth, but is regarded as *more enduring and intense emotionally*, it means showing deep and genuine concern about the welfare of the helpee". When nurses refer to 'tender loving care' they are talking about these responses that Bramner[41] refers to.

It is reasonable to argue that warmth is an emotional response that can be expected from all hospital workers, whilst caring should only be expected from a selective group of workers in particular caring

situations. When Johnson and Martin[42] referred to the support that nurses provide for doctors, they made the point that the nurses assume the responsibility for providing the 'expressive' relationship with the patient and that this is their traditional role; they provide the strongest degree of emotional support for the patient.[42]

Anderson, in her study of nurses, demonstrated how some nurses found most of their intrinsic satisfaction from the relationships that they established with patients, whilst others derived their intrinsic satisfaction from the technical tasks involved in the nursing role. She defined the first category of nurses as patient-orientated and the second category as task-orientated nurses. She recognised that both categories of nurses could be intrinsically involved in their work and suggested that the empathic relationships that the patient-orientated nurses established with patients should not be regarded as the only test of concern for the care of the patients.[43] In this respect she is placing less emphasis than Halmos[44] upon the need to know the patients very well and have a deep insight into their emotional needs.[44]

She is also making the point that the technically-orientated nurses can help the patients just as effectively as the patient-orientated nurses although such help might not be so apparent to the patient, who might be more inclined to identify with the patient-orientated nurse than with the task-orientated nurse. This suggests that all nurses might not fulfil their helping role in a way that would satisfy the criteria established by Halmos[45], who argued that the expression of concerned empathy should not only be expressed by

helpers but that this should be observed by the helpee. He maintains that the prerequisite for professional integrity is the ability of the helper to express the first and second values of personal service orientation.[45]

I have made the point that some nurses might not express the type of empathy defined in the second value of personal service orientation, but this should not invalidate the claim of such nurses that they are effectively helping the patient. The same might be said about the first value of intrinsic involvement; the task-orientated nurses might be helping the patient by carefully monitoring the treatment prescribed by the medicals and this is not always appreciated by the patient.

It is reasonable to argue that the task-orientated nurses who derive satisfaction from helping the patient and who are recognised and appreciated by colleagues and others can express integrity in their caring work. Coser, in a study of two nursing situations in a hospital found one form of nursing to be intrinsically satisfying, whilst another form of nursing created a sense of alienation. Nurses who cared for patients in a rehabilative ward, where patients suffered from polio and respiratory diseases, found their work satisfying, interesting and rewarding. They could see a meaningful relationship between their nursing and the gradual improvement of the patient.[46] In this type of nursing, the nurses were interested in getting to know the patients on a close personal basis. In this situation the nurses expressed the type of 'concerned empathy' that Halmos advocated.[47]

But Coser found another nursing situation, which was concerned

with the care of long-stay patients, to be less intrinsically rewarding.[48] The nurses in this situation tended to devote most of their energies to improving the physical environment at the expense of developing a close personal relationship with patients.[49] Coser argued that these nurses were alienated, but it can also be argued that they should have extended the type of empathy that Halmos[50] was interested in.

It is also interesting to note that, whilst the professional nurses have been gradually developing the technical and administrative aspects of their nursing role, the traditional empathic relationships aspect has been taken over by the non-professional nurses (Schmitt[51], Strauss[52]). It has been argued that lay people have much to offer for developing empathic relationships with patients (Riessman[53]), a point that Halmos[54] also appreciated. But unfortunately, there is some evidence of neglect in this respect where aides and auxiliary nurses were not trained for this aspect of nursing. Indeed, there is considerable evidence that some of the most disgraceful examples of neglect in hospitals have been in the various long-stay hospitals in this country and in the U.S.A., where custodial attitudes have tended to be far more dominant than empathic ones. The most penetrating analysis of this lack of empathy was presented by Goffman in his study of asylums in the U.S.A. This study outlined the depersonalising influences that thwarted the care of patients and brutalised the staff, both professional and non-professional.[55]

Stannard, in a study of an 'Old Folks' Home', described in some detail how patients in private hospitals for old people were neglected and cruelly treated. This study also showed how the professional

staff delegated a high degree of autonomy to the lay nurses and orderlies for dealing with the patients, and how they distanced themselves from the consequences of the care provided.[56]

Some of these studies have drawn attention to the realities of some nursing and caring situations. The solution to these problems extends beyond the authority and values of caring professions because these areas of care are neglected by society as a whole, and in particular by governments meeting the problems of social priorities and the allocation of resources.

The various studies indicate that the type of empathy required in nursing and other caring situations is specific to particular caring situations; there is no simple solution or generalised blanket form of empathy that can meet the individual needs of patients.

Professional integrity

I will now refer to those findings in the literature that I consider to be relevant to the third value of personal service orientation defined by Halmos as professional integrity.[57] Whilst he does not appear to be as precise in his definition of this value as he was for the other two values, he does outline the general characteristics embraced in the third value.

The personal service professional, according to Halmos[58], should have self respect and confidence in his or her ability to help people in need, and this ability should be demonstrated to the client or patient. It should also be demonstrated to those colleagues in

the personal service work culture. The recognition of this ability to help people effectively is regarded as an important source of support and encouragement for the personal service professional. The professional needs to be integrated within the work group and will look for support from his peer group and senior colleagues. He will also be willing to provide the tutelage required from subordinates or aides.[68]

In order to appreciate the nature of this form of professional support in hospitals, we need to take account of the norms and values of the medical professional culture. One can argue that hospital organisations comprise a general sub-culture that embraces a number of specific micro sub-cultures, such as the micro-culture of the operating department or the surgical and medical wards.

Georgopoulis and Mann, in their study of the General Hospitals in New York, referred to the dominant norms of these hospitals as "good care and attention to patients, devotion to duty, loyalty, selflessness, altruism, hard work and discipline".[59]

A valuable source of information which is relevant to understanding professional integrity in the hospital setting is the literature that is concerned with role strain in nursing. Corwin has described how the nurse initially orientated towards bedside care and empathising with patients and improving nursing standards to provide such care, found a great deal of difficulty in adjusting to the administrative tasks related to patient care.[60]

Trail[61], who investigated similar nursing groups to those studied

by Corwin[62], found that there was a relationship between the training that nursing groups received and their nursing aspirations. Degree nurses were much more professionally orientated than diploma nurses and their training placed a strong emphasis upon autonomy and creativity in the nursing role. The diploma nurses were prepared for dealing with the more practical aspects of nursing. The reality of the work experience compelled these nurses to adjust to administrative tasks that they did not anticipate and the nurses had to lower their aspirations and modify the ideal concepts that they entertained during their training, and such adjustments gave rise to role conflict. Trail also established that the degree nurses, with their more idealistic view of nursing, found it much more difficult to adjust to the administrative demands made upon them in their work.[63]

Kramer[64] also came to similar conclusions to Corwin[65] and Trail[66] and referred to this problem as 'role deprivation'. This sociologist showed that one of the reasons why nurses found difficulty in reconciling the professional dimension of their role with the bureaucratic, was due to the contrasting demands of bureaucratism with professionalism. The bureaucratic system was considered to be based on routinised and segmented tasks and, accordingly, does not demand such a variety of skills as the professional system, which is based on the principle that professionals do the whole task which tends to be non-routine in nature.

Kramer[67] argues that this conflict needs to be resolved because it is one of the contributory factors to labour wastage among

dedicated nurses. The problem is one of enlarging the professional dimension of the role at the expense of the managerial administrative dimension.[67] It is important to appreciate that this problem is not confined to senior nurses above ward sister status, because ward sisters and staff nurses who deputise for them, devote most of their time directing and organising ward activities which include maintaining relationships with a wide range of hospital personnel engaged in maintaining the services essential to a well-organised and effective ward.

One can appreciate the point made by Fieldman that nurses experienced a higher degree of role conflict than other hospital employees, such as engineers and radiography technicians, because they had to be responsible to two types of authority; "she is the main link between the head nurse and all other nursing personnel, the main link between the doctor and the patient, and the main link between the doctor and the patient's family".[68] One could also add: links to head porters, porters, ambulance workers, to mention but some of the ancillary occupations in order to appreciate the complex range of administrative relationships that have to be coped with.

Whatever the merits for the case of the nurse as an administrator, because he or she has an overall grasp of the ward as a caring unit, there is no doubt that it does erode the professional aspect of the nursing role with its emphasis upon updating knowledge and skills related to the clinical care of the patient.

One can also appreciate how the professional dimension of the

of the nursing role undermines the traditional surrogate role. Schmitt[69] made the additional point that "This shift of emphasis in the nursing role was undermining the traditional surrogate, supportive affective dimension of the nursing role", or what Corwin[70] would define as the service dimension.

If one considers that the expression of the third value of personal service orientation presupposes that the professional has mastered the first two values, we can appreciate the difficulties that prevent professionals from mastering the various aspects of the first and second values of personal service orientation.

If we consider some of the ways in which the role of the nurse has changed over the years, we can appreciate how the more professionally orientated nurses have had to devote more time to professional and administrative tasks and less time to the empathising aspect of their role.

It is evident that the role of the nurse has been fragmented in a number of ways due to developments in medical technology and the increasing demands of nursing administration. The breadth of knowledge and skill required of professional nurses places considerable demands upon them for expertise in the technical and administrative aspects of their role as well as the empathising aspect. This point was clearly recognised by Anderson when she refers to patient-orientated nurses and task-orientated nurses.[71]

Williams[72] also recognised this point in a study of nursing ideologies when she described how the traditional view of the nurses'

role, perceived in terms of a vocation in an exclusively female occupation, was changing, "nurses have become involved in the work of monitoring complex machinery or carrying out difficult administrative procedures and observations in comparison to which the tasks of feeding and washing sick persons may be regarded as a waste of time".

Nursing is an occupation that has provided a high degree of self-esteem; the sources of this esteem are to be found in the appreciation of the patients, the public and in particular the medicals who should be regarded as an important reference group for nurses.

In view of the fact that Halmos[73] stressed that the prerequisite for expressing the third value of personal service orientation is that the personal service professionals should express the first and second values (skill, knowledge and empathy) and be able to demonstrate the possession of these to the patient, then there is a problem concerning the validity of the concept of personal service orientation. The problem arises out of the complexity of the changing role of the nurses and other personal service professionals who have to cope with a variety of role pressures, when contending with a wide range of expectations yet not satisfying all of them. Kahn *et al.*[74] recognised the nature of the problem in their reference to 'inter sender role conflict' and 'role overload' as broad illustrations of the various forms of role strain experienced by people in work.

It is, in my view, fair to argue that a person can have professional or occupational integrity in their role if they believe in the importance of their work, and if they are endeavouring to contribute effectively

to the goals of the work-group or the organisation. If they feel that this contribution is appreciated and recognised by others in the work situation then this can reinforce the sense of integrity derived from work.

The nurses whom Anderson[75] described as being task-orientated could develop the type of professional integrity that Halmos[76] refers to even if they did not express the degree of empathy that he considers to be so relevant to his third value of personal service orientation. Slocum *et al.*, in their study of nurses, found that they expressed a higher degree of self-esteem than the para-professionals they worked with.[77] This feeling of self-esteem was based on their position in the work situation and also upon the prestige which this occupation was held in in the perception of others in work and in the wider community. They also established that this feeling of self-esteem was closely correlated with such components of intrinsic involvement in work as autonomy and self-realisation.

Carpenter[78] argues that some nurses who are compelled to develop the administrative aspects of their role at the expense of the empathising aspect felt alienated. In this respect, Carpenter[79] agrees with Corwin[80] and Traile[81], although the latter two note that some nurses like administrative work. We can appreciate that if professional nurses become more involved in the technical and administrative aspects of their nursing role, then much of their traditional empathising work will be undertaken by nursing aides and also by hospital ancillaries. There is considerable evidence that this is the case in the U.S.A. according to Burz[82] and Schmitt[83].

It will be interesting to consider the extent to which the aides and ancillaries develop this aspect of their role and the extent to which they become intrinsically involved in their caring work. It will also be interesting to consider the extent to which the aides and ancillaries received the type of support and tutelage from nurses that Halmos envisaged.[84]

Intrinsic involvement: Aides and ancillaries

I will now discuss the findings of those sociologists who have studied the nature of the contribution to patient care of nursing aides and ancillaries. Most of the published studies in this country and in the U.S.A. have referred to the intrinsic satisfactions that aides and ancillaries have experienced in their work. They also place considerable stress upon contact with patients as a major source of intrinsic satisfaction.

Williams *et al.*, in their study of two London hospitals, made this point - "The majority of staff at both hospitals thought that their hospital was a good place in which to work". The main features which were liked were the work itself: the fact that ancillary staff felt they were helping patients in being allowed to get on with their work without being too heavily supervised.[85] Satisfaction from helping patients should be regarded as one of the main components of the first value of personal service orientation with its emphasis upon the application of knowledge and skill in helping patients. It is also interesting to note that the satisfaction from the use of knowledge and skill has been widely recognsied by other sociologists interested in personal service roles and industrial roles.

Dale[86], in a study of domestics focused upon the locations where they worked and argued that certain hospital locations offered work which was very predictable, such as offices and residential homes. Other work locations offered a greater variety of work. This was the case in the paediatric, maternity, medical and surgical wards. Dale then focused upon the organisational characteristics of the locations and divided them into two categories. The first category was characterised by an 'organic' organisational structure, the second category was characterised by a 'mechanical' structure.[87] Role relationships in 'organic' locations were not so tightly structured as the 'mechanical' locations since they had no pronounced status hierarchical system and communications were based on lateral lines. 'Mechanical' locations were highly stratified, with roles clearly defined, and communication based on vertical lines.

Dale established that the work location that was most popular and satisfying for the domestics was the maternity ward, which he described as an 'organic' location. The most dissatisying work locations were the offices and residential homes, which had a high degree of predictability with their 'mechanical' structure.[88] Allowing for the consideration that domestics are naturally interested in children, the findings of Dale[89] suggest that hospital domestics can experience intrinsic satisfactions in certain locations in the hospital.

Dale[90] also established that the tasks that were intrinsically satisfying in hospital wards for the domestics, were what might be

described as 'fringe' nursing activities, such as filling the water jugs, tidying the patients' lockers and talking to patients. Whilst these tasks did not demand a high degree of technical skill they were meaningful and satisfying and, although the domestics might not express all of the values of personal service orientation, they could express some of them, particularly some of the components of the first value that were linked with satisfaction from meaningful work, that made use of one's skills and created a desire to obtain new knowledge.

According to Dale[91], the nature of the work in the hospital wards provides various degrees of scope for intrinsically rewarding work of the type referred to in the first value of personal service orientation. Whilst Dale[92] did not specifically refer to the degree to which the domestics empathised with patients, it is reasonable to believe they did empathise with them when we consider the satisfaction they had from the fringe nursing activities, particularly in the maternity ward.

A study of hospital porters by Saunders[93] also found some evidence that porters were involved in work that they perceived to be intrinsically satisfying. Saunders referred to two sources of intrinsic satisfaction. The first source he described was the contact that porters had with patients and their involvement with medical and nursing groups. It is interesting to note that the porters who obtained this form of work satisfaction, appreciated what they were taught by nurses and medicals. He also remarked that porters "perceived their role as caring aides .... this gave them an identity and they felt part of the team",[94]

The second source of satisfaction of an intrinsic nature that Saunders referred to was the variety of tasks and duties offered in portering work. The variety of work featured more prominently among the porters who worked on rotating shifts when employed in a pool of porters, expected to move around the hospital to meet particular needs when they arose.[95] Saunders also suggested that porters who obtained experience of pool work had a comprehensive view of all aspects of hospital work.[96] It is interesting to note the view of Susman, an industrial sociologist, who argued that some of the opportunities for intrinsically rewarding work is related to physical mobility which provides a wide perspective of the work in the organisation.[97]

It should, however, be noted that Williams *et al.*[98] found that most porters did not like to work in a pool where they might have to move about the hospital, because they wanted to be identified with a particular work group directly involved in patient care. Williams *et al.* agree with Saunders that many departmental porters located in wards or other therapeutic units appreciate the training they receive from medical and nursing staff.[99] Saunders had this to say about the hospital porters: "Moreover many departmental porters are given training by medical and nursing staff, and are thus more able to experience growth in knowledge and skills, and gain a greater feeling that they are making a positive contribution to patient care".[100] This description of the work involvement and work relationships of hospital porters illustrates the type of support that Halmos expected personal service professionals to give to the lay workers who aided them. It also demonstrates the willingness of lay workers to train

for their work.[101]

Williams *et al.*[102] and Saunders[103] demonstrate that porters want to be intrinsically involved in their work and will respond to professional support which improves their contribution to patient care in a way envisaged by Halmos.[104]

Empathising with patients

The scope for ancillaries to empathise with patients has been referred to when I discussed the changing role of the nurse, earlier in this chapter. Schmitt[105] and Strauss[106] recognised that as professional nurses became more involved in their technical and administrative duties the empathising aspect of their traditional role would be gradually taken over by nursing aides or auxiliary nurses.

There is some firm evidence about the empathising aspects of the nursing aides' role from the studies of Burz[107] and Handschu[108]. Burz found that most of the nursing aides in a group of nursing homes in the U.S.A. perceived that their main function was to provide a strong measure of emotional support for the patients. They were also of the opinion that they were much more familiar with the patient as a person than were the professional nurses they they were responsible to.[109] These nursing aides perceived themselves as the most important persons responsible for the care of the patient. They knew the patients on a very intimate basis and they were involved in bathing the patients, keeping them clean and also in feeding them.

Burz also established that the main source of dissatisfaction

for the vast majority of the nursing aides was the lack of recognition they had for their work from the professional nurses.[110] Burz[111] argued that nursing aides who did not receive support and appreciation from professional nurses experienced a high degree of role strain.

Handschu[112], in a study of nursing aides in geriatric homes in the U.S.A. found that most of the aides were satisfied with work which demanded a close understanding of the individual patient's needs. There is also considerable evidence in this country about the particular contribution of nursing auxiliaries. Johnson has argued very strongly that the untrained auxiliary nurses are much closer to the patients than the trained SRNs, although he suggested that this did not apply to SENs with their practical skills orientation to nursing.[113]

Most of the studies that have been concerned with ancillary workers have recognised the satisfaction that ancillaries derived from helping patients. Saunders, in his study of porters, indicated that the most dissatisfying tasks were those that did not involve contact with patients.[114] The nature of the personal relationships that porters establish with patients is illustrated by this comment made by Saunders:

> When patients are under constant medical treatment, or long term, they really get to know the porters, often by name. One frail old lady insisted that a porter take 10p every time he brought her a cup of tea. Patients strike up a rapport with the porters although one might expect a great deal of anonymity in hospitals of this size." [115]

Another example of porter-patient relationships was presented in a local newspaper about the work of Colin Davies, a hospital porter

working in an out-patient ward in East Glamorgan Hospital, who received 540 Christmas cards from patients and relatives, as well as many gifts. *

Whilst Williams *et al.*[116] and Dale[117] stressed the intrinsic satisfactions that ancillaries had through their contact with patients, they did not go into great detail about the type of emotional support they provided, but it is reasonable to assume that ancillary workers would bring some warmth and understanding to patients needing emotional support.

We can note that many of the studies relating to the role of ancillary workers in hospitals refer to the importance of personal relationships in the work role of porters, domestics and others, but there is very little evidence of training for these workers. It should, however, be noted that the King's Fund, in its Report in 1974, on the training of porters, recommended training for this aspect of their work.

There is, then, some evidence that aides and ancillaries express some degree of empathy for patients, even if it is more limited than the type of empathy envisaged by Halmos[118]. It will be interesting to consider the extent to which ancillaries were supported for this aspect of their work by nurses and other personal service professionals. It is reasonable to argue that a strong degree of support and appreciation from nurses, doctors and other professionals should provide some degree of occupational integrity for ancillaries. Even if the ancillaries are not expressing the first value fully, they should derive some degree of integrity from the empathising aspect of their

* South Wales Echo, 23.12.1977

role, which provides some degree of emotional support for patients.

Occupational integrity

Industrial sociologists such as Blauner[119], Faunce[120] and Shepard[121] agree that a person's occupational identity is one of the most important sources of self-esteem. Faunce refers to the significance of a view expressed by Everett Hughes, a well respected industrial sociologist who said, "a man's work is one of the things by which he is judged and certainly one of the significant things by which he judges himself".[122] This particular comment has much in common with the concept of professional or occupational integrity defined by Halmos[123]. The Concise Oxford Dictionary defines integrity as "Wholeness, soundness, uprightness, honesty". If an ancillary worker relates these qualities to his or her contribution to patient care, either through technical skills or through empathy, then this should be a firm basis for occupational integrity.

It is also important to note the importance of the regard and respect of significant others as a source of self-esteem, or occupational integrity. Shibutani[124] argues very strongly about the importance of reference groups which can nurture a person's occupational identity through recognition and praise.

In view of the emphasis that Halmos[125] places upon the socialising role of personal service professionals in relation to the development of aides and ancillaries, it will be interesting to examine the evidence in the published literature concerning the degree of support that ancillaries experience in their relationships with nurses and other personal service professionals in hospitals.

Burz found that nursing aides were not satisfied with the support that they received from the trained nurses. They were unhappy about the lack of training for many of the tasks that they were asked to undertake, and they expressed the view that they were often involved in tasks that they considered to be the responsibility of the trained nurses. Examples of such work were administering oxygen to patients and taking their blood pressure. They also complained of being allocated menial tasks which should have been given to orderlies, such as washing the patients' clothes.[126]

Stannard[127], in a study of a geriatric hospital, found that nursing aides were engaged on nursing tasks which they were not trained for. Neither were the nursing aides supervised by the trained nurses for these nursing tasks.

Johnson[128] made the point that auxiliary nurses receive very little encouragement to develop their nursing skills,

> ...the unqualified nurse is in many ways the person carrying out the most vital of the nursing duties. She has constant contact with the patient and is frequently the one to whom they turn both for comfort and information. As a result there is a real basis for job satisfaction to be derived from patient contact gratitude and the projection of *higher capabilities than their training warrants.*

Johnson also noted that "the auxiliary with no credentials to gain and no career structure to climb faces different alternatives. She too might resign and seek other work but the auxiliary is by definition an unqualified person *whose marketability is low.*"[129]

If we now turn to hospital ancillaries we find that many of the published studies refer to the concern of domestics and porters about the lack of appreciation from nurses for their work. Coghill[130],

Jeffries[131] and Saunders, in his study of porters, quoted the porter who expressed the view, "We consider that we are regarded by all and sundry as general dog's bodies".[132] Williams *et al.*[133] also noted this dissatisfaction, "No direct questions were asked about the status of ancillary staff, but the replies to a number of questions indicated that many staff considered their status in the hospitals was low and that they were treated with a lack of respect. The subject was obviously a cause of considerable concern for a number of respondents". The report of the Royal Commission on the N.H.S. in 1979 also noted the importance of status: "Many ancillary staff considered that their status in the hospital was low and that they were treated with thoughtlessness and a lack of consideration particularly by some members of the young nursing staff".

The evidence referred to indicates that most ancillary workers do not perceive themselves as workers whose contribution to patient care is appreciated. If we consider that the opinions of significant others such as nurses is an important source of socialisation according to Halmos[134] and Shibutani[135], then one can reasonably infer that many of the ancillaries do not possess a strong sense of self-esteem.

We know that some of the reasons for the low sense of self-esteem of many industrial workers is attributed to the low degree of skill of many of them, particularly the semi-skilled and unskilled workers. Faunce argued that certain jobs demanded skill and responsibility and that it is "pride in these attributes and the recognition of them by others which is the key to self esteem".[136]

I have examined the published findings which are concerned with

the nature of the role of hospital ancillaries in their work. The findings suggest that there is no strong evidence to support the view that ancillaries expressed a strong personal service orientation in their work in terms of the criteria outlined by Halmos[137]. We can appreciate that most of the studies that were referred to were confined to domestics and porters. These particular occupations do not entail work that is regarded as highly skilled and one might argue that their work does not provide a firm basis to provide the type of motivation that Halmos outlined in his description of the components of the first value of personal service orientation[138]. The published findings do, however, suggest that domestics and porters expressed some of the components of the first value in their work activities. Most of the studies recognised that these ancillaries perceived their work to be meaningful and worthwhile. They also found their work to be interesting and intrinsically satisfying. The findings of Coghil[139], Dale[140], Jeffries[141] Saunders[142], Williams *et al*[143] and Woodward[144] provide strong support for this type of work involvement. There is, however, no strong evidence to suggest that these ancillaries were involved in technical tasks that provided scope for self-realisation.

Whilst these studies did not refer specifically to the empathising aspects of the work of the ancillaries which would satisfy the criteria of 'concerned empathy' as defined by Halmos, which constituted his second value, it is evident that helping patients is a source of intrinsic satisfaction for many domestics and porters.[145]

When we consider the evidence relating to the third value defined by Halmos as professional integrity, it needs to be stressed that the prerequisite for expressing it is that the person expresses the

occupational integrity is through being involved in a ward or work group team which they can identify with. This suggests that ancillaries want to be recognised as workers who make a real contribution to patient care.

It is evident that the three values of personal service orientation relate to the work activities and relationships of hospital ancillaries. Some of the components of these values appear to be more important than others. The findings from the literature also indicate that personal service workers are interested in having some degree of influence through work-place participation.

In my introduction to this thesis, I referred to the need to establish whether the pattern of intrinsic involvement in personal service work differed in a significant way from the patterns of intrinsic involvement experienced by industrial workers. The findings referred to in the discussion of the literature suggest that, whilst the personal service workers are concerned with work related to the care of people who are sick, industrial workers are concerned with material end products or commercial services, but both groups of workers have much in common in respect of the need to develop their personal resources. Both groups of workers can experience alienation in their work. Both groups of workers can experience role strain in their work if they find that their intrinsic aspirations are not realised. Both groups of workers are capable of generating intrinsic aspirations in their work as a result of work experiences that they did not anticipate.

It is also evident, in the discussion of the literature in

first and second values.[146]

It is evident that the criteria that Halmos laid down for the three values of personal service orientation might be considered to be too demanding and unrealistic for such ancillaries as domestics and porters, who are traditionally regarded as low skilled workers.[147] The findings that I have referred to in this chapter demonstrate that certain aspects of the work of these two ancillary groups are intrinsically satisfying. The most important source of satisfaction are the tasks that are directly related to patient care, which ancillaries consider to be meaningful and worthwhile. We can appreciate that many porters and domestics find their work interesting and even challenging with its demands for tact and empathy.

Whilst the work of the domestics and porters might not demand a high degree of technical skill, and will not provide a great deal of scope for them to be involved in all of the components of work embraced in the first value of personal service orientation, there is evidently scope for empathising with patients.

It is also evident from the literature, that porters and domestics are concerned about the lack of appreciation and regard from such significant others as nurses. This concern suggests that they want the type of integrity that Halmos considered for professionals and what many industrial sociologists refer to as 'self-esteem'.[149]

It is also important to note that the studies referred to recognise that one of the ways for ancillaries to obtain self esteem and

chapter one, that the expectations of personal service and industrial workers indicate that extrinsic rewards are very important. The findings suggest that the opportunities for satisfying intrinsic aspirations are far more limited for the lower skilled workers than they are for those with skills

The components of the first value of personal service orientation are similar to the components of intrinsic involvement in work referred to by other sociologists. It seems that the main difference between personal service workers and industrial workers is that the former group relate their efforts to helping people in need, whilst the latter group relate their efforts to material products or commercial services.

Halmos argues that helpers who use their skills and knowledge in meaningful work that is intrinsically satisfying are expressing the first value[150]. Blauner, in his study of printers, found that they were intrinsically involved in their work by using their skills and knowledge in a meaningful and satisfying way by providing a commercial service.[151] He also recognised the importance of workplace participation as a significant component of intrinsic involvement because it enabled printers to exercise some control over their immediate work environment.[152]

It is possible to measure the extent to which hospital ancillaries expressed the first value by focusing upon the Halmos criteria[153] and also satisfy the Blauner criteria[154] of intrinsic involvement, particularly if one includes the component of workplace participation

with the other components. We can also modify the criteria laid down by Halmos for the second value, 'concerned empathy'.[155] If we take a less demanding view of empathy than that of Halmos and consider ancillaries who would like to know patients casually, we can have a firm basis for measuring the extent to which non-professionals who are not expected to have close personal relationships with patients, express concerned empathy.[156] It can also be appreciated that certain forms of caring work demand close personal relationships with clients and patients. Tomlin, a consultant surgeon, found that nursing in intensive care wards is more emotionally demanding and stressful than other nursing situations.[157]

Whilst allowing for the variations in caring situations that nurses and other hospital workers experience, it is reasonable to assume that most hospital workers have to respond to those patients who want emotional support in some form or other. This need was clearly identified in the work of Anderson in her study of the relationship between nurses and patients.[158] Whilst Halmos argues that personal service workers should know their clients and patients well and empathise with them, this is not always possible. Indeed, he recognised that surgeons were not in a strong position when it came to knowing the patient and realised that, if they became too detached from their patients, they could lose their sense of personal responsibility for the individual in their care. This recognition of the surgeons' difficulty in empathising with their patients is also relevant to others in similar situations, such as theatre nurses and theatre assistants.[159]

In my view, since it is not possible for some ancillaries to know

the patients very well, they can respond to the emotional needs of patients by displaying the warmth that Brammer considers to be relevant to caring occupations.[160] The ability to empathise at this level is appropriate to the role of most ancillaries. In this study I believe it reasonable to consider those ancillaries who 'would like to know the patients casually' as people who are empathising in a proper manner. They might not be trained to deal with the emotional needs of patients but they can offer warmth through a smile, a casual word of encouragement.[161]

When we come to the third value professional or occupational entegrity that Halmos stresses, we must take into account the fact that ancillaries are not always in a position to credibly and plausibly impress the patient that the first two values are 'diligently and consistently advanced in his interest' and very often their contribution in this respect needs to be confirmed and validated by such key personal service professionals as nurses.[162] The vast majority of ancillaries who come into contact with nurses have some form of working relationship with them and often this is related to patient care. It is reasonable to assume that the appreciation of nurses can be an important socialising influence for ancillaries. In this respect nurses represent a very important reference group for ancillaries. The support and appreciation of nurses is essential for ancillaries to undertake their duties with confidence and this is of particular importance when this supportive relationship between nurses and ancillaries can be seen by the patients. It is in such a context that ancillaries can maximise their performance as caring workers and express the third value of personal service orientation;

professional or occupational integrity.[163]

By examining the degree to which ancillaries express the three values of personal service orientation, we will have the opportunity to test the validity of the hypothesis advanced by Halmos that significant others in the personal service professional culture have a normative obligation to nurture the contribution that their aides and ancillaries provide for the helpees.[164] It is, however, important to recognise that work cultures are not static entities and that they only exist through the activities of the people who participate in it. In this respect the relationship between the theatre assistants with the medical nursing groups that they work with in the operating department (in what might be described as a particular micro-culture that functions within the wider sub-culture of hospitals), is an ideal place to test the Halmos hypothesis concerning professional tutelage for ancillaries.[165]

In the introductory chapter, I referred to the similarity and the degree of commonality between the components of the first value of personal service orientation and the components of intrinsic involvement in work defined by other sociologists. There is also some resemblance between the components of the third value as defined by Halmos, which he describes as the value of professional integrity and the various concepts of self-esteem which industrial sociologists consider to be relevant to intrinsic involvement in work.[166]

Faunce[167] and Shepard[168] have referred to the importance of feedback from significant others as a source of self-esteem. Shibutani also recognised the importance of recognition by significant others

in professional reference groups as an important source of nurturing a particular occupational identity that is valued by those who aspire for acceptance in professional work cultures.[169] It is reasonable to argue that ancillaries who are appreciated by nurses and encouraged by them in their caring work, will develop the type of confidence which many industrial sociologists consider to be a basis for self-esteem. It should also provide the type of confidence that Halmos placed such stress on when he defined professional integrity in his third value of personal service orientation.

It is apparent, then, that the first and third values of personal service orientation embrace components which have much in common with the components of intrinsic involvement in work that industrial sociologists have identified in industrial situations and which personal service sociologists have identified in occupations concerned with helping people in need. What is clearly demonstrated is that 'concerned empathy' is the value that contains components which are peculiar to caring and helping personal service occupations.

The discussion of the literature suggests that the components of the three values of personal service orientation are, in general, not very different from the components that other personal service sociologists have recognised in their studies of such personal service professionals as nurses. What is of particular significance about the concept of personal service orientation is the emphasis that is placed upon the influence of the personal service professional work cultures as determinants which shape this pattern of involvement in work.

Summary

In this chapter I have reviewed the literature that focused upon the intrinsic satisfactions that nurses, nursing aides and hospital ancillaries experienced in their work. There is considerable evidence from the findings that I have referred to, that nurses were more intrinsically involved in their work than the aides and ancillaries. It is also evident that nurses benefited from professional training and preparation for their caring role. The evidence relating to the aides and ancillaries indicated that they did not receive any form of structured training for their work. Their training in the main was confined to learning on the job and, in this respect, they depended a great deal upon the support of nurses and doctors.

In chapter one I referred to the findings which suggested that nurses had strong intrinsic expectations of the nursing role. In this chapter I identified a number of situations where nurses could not fulfil these expectations and this was responsible for a feeling of alienation and role deprivation. It was also suggested that the dissatisfaction expressed by nurses was reflected in high rates of labour turnover.

In the case of ancillaries, I noted in chapter one, that their expectations were predominantly of an extrinsic nature, yet it is evident from some of the findings discussed in this chapter, that they experienced intrinsic satisfactions in their work. Burz, in her study of nursing aides, established that the main sources of intrinsic satisfactions were found in the aides' involvement in patient care. But she also found that the main sources of dissatisfaction

for aides were the lack of appreciation and recognition of the professional nurses.[170]

The findings examined in this chapter suggest that aides and ancillaries found certain aspects of their work to be intrinsically satisfying (Burz[171], Handschu[172], Saunders[173] and Williams *et al.*[174]). It also emerged that many aides and ancillaries possess the personal attributes for empathising with patients that Halmos[175] and Riessman[176] value. The findings suggest that, whilst aides and ancillaries were involved in work activities that satisy the criteria for the first and second values of personal service orientation, this is not the case for the third value, occupational integrity. In view of the importance of professional tutelage as a major source of encouragement for ancillaries, the failure to provide this support is not conducive to nurturing a sense of occupational integrity among aides and ancillaries. It is reasonable to conclude from the research referred to in this chapter that the personal service professional culture is not fostering the type of socialisation for non-professionals envisaged by Halmos.[177]

It is evident that aides and ancillaries depend a great deal upon support from medical and nursing groups not only to acquire knowledge and skills, but also the self-confidence which is the basis of occupational integrity and self-esteem. Aides and ancillaries occupy subordinate roles in the personal service professional culture. Compared with nurses, aides and ancillaries have no indigenous occupational culture which is rich enough to draw upon to enable them to maximise their work performance in the way perceived by

Halmos.[178] Whilst nurses have traditionally depended a great deal upon medical groups to validate their role, they are now exercising a greater degree of independence in this respect. The aides and ancillaries are evidently not in this position and need the support of medical and nursing groups if they are to fulfil the potential that Halmos[179] and Riessman[180] consider to be so important in personal service helping caring work.

In the next chapter, I will discuss my empirical research. I intend to test the Halmos hypotheses that ancillary workers work in a personal service professional culture will develop a personal service orientation and that the main determinant of this orientation will be the support and tutelage of medical and nursing groups.

CHAPTER THREE

THE ROLE OF THE HOSPITAL ANCILLARY WORKER

In this chapter I will discuss the findings of my empirical research into the role of the hospital ancillary worker. I will firstly describe the method that I applied to study five occupational groups of hospital ancillaries. Secondly I will describe the occupational characteristics of these groups and consider the extent to which there is potential in their work roles for them to express what Halmos described as personal service orientation in their work. Thirdly, I will examine the attitudes expressed by the hospital ancillaries to those aspects of their work which were related to the first and second values of personal service orientation. I will be particularly interested in the theatre assistants, because they belong to an occupational group that works closely with such personal service professionals as consultants, doctors and nurses. In the context of the Halmos hypotheses about the socialising influence of these professionals, it will be interesting to consider the extent to which ancillaries who support medical and nursing groups benefit from their tutelage.

Halmos[1] argues that the values and norms of personal service professionals will be assimilated into the system of values and beliefs of most of the workers who participate in their work culture. Whilst he is mainly arguing the case for such personal service professionals as doctors, nurses and social workers, he is also presenting the case for the lay workers who serve as aides and ancillaries for the professionals.

One of the most promising areas for examining the Halmos hypotheses concerning the relationships between personal service professionals and the aides and ancillaries who support them, is the hospital service. The hospital is a caring institution that has been influenced by one of the most influential of the personal service professional groups, these are the medicals. The medicals, supported by professional nurses and para-medical groups have developed a personal service professional culture that is based on the central value of patient care. This value is considered by many to be one that integrates a diverse range of professional and non-professional groups irrespective of the differential economic and social rewards that they derive from their work (Strauss[2]).

The instrument that I used to investigate the role perception and experience of the hospital ancillary was a questionnaire designed to measure their role expectations, the nature of their role involvement and work satisfaction, and the degree of support they had from professionals and the role strains they encountered in their work. It can be appreciated that the questionnaire, as an instrument in sociological research, has its limitations. Whilst it can reveal the broad framework of occupational roles it does not reveal the intricacies and sensitivities of role perception, role relationships and experiences.

In order to probe in more depth the issues raised by the questionnaire, a series of structured interviews of an hour's duration was undertaken with a group of 50 ancillaries, representative of the five main occupational groups. In addition to these interviews, I conducted a series of group discussions with three groups of hospital

ancillary supervisors and with two groups of hospital ancillary shop stewards on those aspects of the ancillary's role with which they were involved.

Ancillary workers in the hospital service fall into thirteen main categories embracing over 150 occupations. Seven of the categories cover male workers and six of them female. The occupations vary in their degree of skill and range from crafts that require an apprenticeship period to the domestics who only receive an initial two days of training or none at all.

It is estimated that over 220,500 ancillary workers are employed in the hospitals in Great Britain and work in some 2,900 hospitals.* The largest of the occupational groups are the domestics of whom there are 100,000, followed by catering, 40,000 and portering, 20,000 and laundries, 10,000. The other occupations range from gardeners to theatre assistants. Most of the occupations are primarily concerned with manual technical tasks, although certain occupations such as house-keepers and store-keepers, undertake clerical and minor administrative tasks.

About 28% of the ancillary workers are men who work full-time, with only 2% of them employed part-time, working less than 40 hours a week. The remaining 70% of the work force are female ancillaries and, of these, half of them work full-time and the other half part-time. In terms of economic cost, these workers constitute 32% of the labour force, 30% of total labour cost and 21% of running costs.

Most of the ancillary workers that I will be concerned with, are

* National Board of Prices and Incomes Report 169, 1971, NBPI.

those in occupations that bring them into close personal contact with patients. These are theatre assistants, ambulance workers, porters and domestics. I will also be concerned with maintenance craftsmen, one of the ancillary groups which is not closely involved with patients. I chose to study these groups of workers because of my teaching involvement with ancillary supervisors and the special interest in their work which I have developed. Whilst there has been some research into the role of porters and domestics, there is no evidence of any research into the role of theatre assistants and ambulance workers in this country. I believe that my work will describe their role to a wider public and make a contribution to sociology, particularly that aspect which is concerned with the role of personal service ancillary workers.

The locale for this research was in the area that now constitutes the new South Glamorgan Area Health Authority. This area was chosen because I had easy access to it and because I had established personal contacts there with some administrators, trade union officials and individual workers. This area was also suitable because there were a large number of general hospitals in it.

The sample chosen for this investigation is not a random sample. The sample comprises those ancillaries who were accessible at the times that did not interfere with their work. There were a number of difficulties that prevented a random sample. In order to gain approval for this research a number of senior administrative officers in the hospitals had to be approached, as well as trade union full-time officials.

The sample

In order to achieve the goodwill for this research, I had to obtain the support of a number of ancillary supervisors. It was not easy to contact these supervisors in their workplace and I also had some difficulty in contacting the ancillary workers in the sample. Ambulance workers spent a great deal of their time on the road and would often have their meals away from their work base. Theatre assistants were usually working under considerable pressure and were not always available during their break periods. It was also difficult to contact porters and domestics who were working on early or late shifts. In spite of the difficulties, most of the people who were asked to be involved in my survey cooperated.

The sample of 181 ancillaries consisted of five occupational groups. Four of these groups could be defined as personal service ancillaries who were in close contact with patients. The other group, the maintenance craftsmen, were no so closely involved with patients. These ancillaries worked in a number of hospitals in South Glamorgan.

All of the theatre assistants in the sample worked in all of the hospitals that were covered in the survey. All of the theatre assistants in these hospitals were invited to respond to my questionnaire and most of them completed it. The other ancillaries were drawn from the other hospitals with the exception of the ambulance workers, who worked in the City of Cardiff Ambulance Service before they became part of the Area Health Authority of South Glamorgan in 1974.

It is important to stress the point that the sample was not a random sample and could be defined as a sample of convenience. In

view of this limitation, there is no basis for generalising about the position of the porters, domestics, ambulance workers or craftsmen. It is, however, reasonable to generalise about the position of the theatre assistants for this particular locality but not on a wider regional or national basis. The sample is presented in Table 1.

TABLE 1

POPULATION SAMPLE

OCCUPATIONAL GROUPS

PLACE OF WORK	AMBULANCE	THEATRE	PORTERS	DOMESTICS	CRAFTSMEN	ALL
Teaching (large) Hospital	-	19	3	2	7	31
Old (medium size) Hospital	-	10	21	36	7	74
Small hospital(s)	-	16	15	12	7	50
Ambulance service	26	-	-	-	-	26
Number in sample	26	45	39	50	21	181
Number employed in the established occupations in 1974	153	52	390	1029	152	1776

It is evident that in only one of the occupational groups in Table 1 is there a sample that is representative of the occupational population in the locality. These are the theatre assistants, where 45 out of the 52 theatre assistants responded to the questionnaire. This particular group is one that is very important to this study because they are the only ancillaries that happen to work very closely with both medical and nursing groups in the personal service professional culture of the operating department.

In this study I will be primarily concerned with the theatre assistants, but I shall be comparing their work role with the work roles of the ancillaries from the other occupational groups who are not as closely involved in a personal service professional work group. It will also be possible in this sample to sub-divide the theatre assistants into three groups. One group will be from the large teaching hospital, another will be from an old medium-size hospital. The others will be drawn from the smaller hospitals in the locality.

Occupational characteristics of ancillary groups

A brief description of the work of the hospital ancillaries will illustrate the technical nature of their tasks, as outlined in their job descriptions. It will also indicate the degree of their involvement with the patients and the relationships that they have with other occupational groups in the hospital. If we focus our attention upon the personal service ancillary groups, we find that most of them were engaged in a supportive role to the professional groups in the hospital. There are, however, certain characteristics which are peculiar to each group. The groups which will be described are theatre assistants, ambulance workers, porters, domestics and maintenance craftsmen.

Theatre assistants

Theatre assistants are primarily concerned with supporting the anaesthetist and the surgeon in the operating theatre. Originally this occupation was regarded as a portering job and there is a certain

degree of overlap between theatre porters and theatre assistants in some hospitals. The theatre assistant has now become a specialist job in its own right and in the large hospitals there is a considerable degree of specialisation amongst theatre assistants, such as those working on coronary cases or in general surgery.

The skills and knowledge required of a theatre assistant have increased considerably over the last decade, because of the complexity of operating techniques and the proliferation of surgical and medical knowledge. Much of the work of the theatre assistant is done under considerable pressure, whilst they are working as part of a team with anaesthetists, surgeons and theatre nurses. There are others who work in the coronary care and dialysis wards where they are directly involved in helping the patient. In the coronary care unit the patient is on a ventilating machine which is inserted into the trachea tube of the patient to help him to breathe. These theatre assistants have to turn these patients over every two hours to ensure adequate blood circulation. Similar duties are performed with the patient on the kidney machine in the dialysis unit.

The contact which these assistants have with the patients is of crucial importance and takes place at critical periods in their lives. Much of their work is concerned with caring for the patient in a gentle and reassuring manner. This reassurance can take place before a patient is sedated and prepared for the operation, or after the patient regains consciousness after it. This type of contact occurs once or twice in a patient's life, but the theatre assistant who works in the coronary wards may be in continual contact with a

patient, taking him to and from the ward to the operating theatre on more than one occasion.

These men work under considerable pressure and, because of the shortage of attracting people to this job, they have to work, on occasions, as much as 17 hours a day under intense pressure. This occupation is similar to that of the ambulance men who are enlarging the patient care element of their role. Theatre assistants now receive an intensive two years training and it is intended, according to the Lewin Report recommendation of 1970, that they should be trained to relieve theatre nurses of some of their duties. Some nurses, however, have certain reservations about the Lewin Report recommendation because they see this as an encroachment upon their traditional nursing role. This situation often causes role strain between the theatre assistant and the theatre nurse. This is particularly pronounced when the theatre assistants want to enlarge this role and if this is resented by the theatre nurses.

Ambulance workers

Ambulance workers have moved a long way from the popular image of being ambulance drivers with a knowledge of first aid. Their work is now based on an amalgam of technical, nursing, para-medical skills. Their duties and responsibilities fall into two main categories. They are responsible for transporting patients to hospitals, clinics and other centres of medical care. They can also be involved in emergency service duties. These duties place demanding expectations upon their ability to respond to urgent calls to deal with accidents of varying degrees of severity and to deal with a sudden illness such

as a patient experiencing a coronary attack. Their work has been described as being of a practical nature which requires considerable theoretical training. They also require personal qualities, such as a willingness to accept a high degree of individual responsibility and a dedication to duty. They often work without immediate supervision and carry a great burden of responsibility which they have to shoulder alone, or with another colleague. In view of the demanding nature of this work we can appreciate that those who take up this job identify closely with the service to which they belong and have a strong sense of vocational commitment.

In spite of the skills and knowledge which is essential for their work, their training is brief and consists of a six weeks proficiency course, followed by refresher courses of two weeks duration. A great deal of their training can take place 'on the job' and, in this respect, they are in the same position as the theatre assistants.

Unlike the other ancillaries, ambulance workers have not been employees of the hospital service or, indeed, of the NHS, because they were employed by the local authorities until they were brought into the area health authorities in 1974 as a consequence of the legislation concerned with reorganising the NHS. Their organisational structure and career structure resembles the Police Force and the Fire Service in respect of its strong hierarchical structure. In the ambulance service, the supervisors are ambulance officers and career opportunities are linked to promotion to officer grades. It is interesting to note that ambulance workers perceive themselves as workers in an emergency service and when they submit their wage and salary claims, they seek some degree of parity with policemen and

firemen.

Ambulance workers, however, have a great deal in common with ancillary workers because of their involvement in patient care. But, unlike most of the ancillaries who belong to caring teams in the ward or in the operating department, ambulance workers either work on their own or in pairs. They usually work on their own when they transport patients for outpatient care or for various forms of treatment in health care centres. In this type of work situation they can develop close personal relationships with the patients and they provide the form of empathy that Halmos considered to be so important. They will usually work in pairs when engaged on emergency service when they have to respond to the various demands made upon them, which can range from dealing with an alcoholic to attending a serious road accident. In these situations the relationships that they have with patients can be stressful. They often work unsupervised and carry a great deal of responsibility which they must frequently shoulder alone. They can establish a close relationship over a long period of time when patients are enduring an illness and are helped by the ambulance worker to be conveyed to the hospital for outpatient care, or to such specialist clinics as the chiropody clinic, for continual treatment.

Porters

The duties of hospital porters involve them in the work of many departments and wards. They provide support for the following departments: maternity, mortuary, pharmacy, physiology, psychiatric, operating department, and orthopaedic. Their work with these departments and wards enables porters to meet patients and also to

meet a wide range of medical, nursing and para-medical staff.

In a large hospital, a head porter will be supported by a deputy and by charge porters, who are responsible for supervising the other porters who fall into the lower grade and lower paid categories of ancillary workers, according to the Ancillary Staffs Council classification.

In many hospitals, porters are divided into two broad groups. The first group will comprise porters who are permanently based in particular departments or wards, or in the operating department. Others in this group will work as receptionists or in the laundry. The second group of porters will work in a 'pool' where they can be rotated around the hospital to undertake various duties. Some hospitals might prefer to organise all of their porters on a permanent basis, or they will place all of them in a portering pool.

In spite of many proposals, such as the one presented by a working party of King Edward's Hospital Fund in 1968, no comprehensive scheme for training porters on a national basis has been introduced. Whilst various local schemes have been introduced to provide some element of training, there is still a long way to go before the proposals recommended by this working party are realised.

Much of their work is concerned with patients. They can receive patients into the hospital and they will probably escort a patient from the ambulance or other vehicle to the hospital ward when the patient enters the hospital. When the patient is discharged, they will escort him from the ward to the ambulance. They will also wheel patients to and fro; to the X-ray or Physiotherapy Departments or to other therapeutic centres. They are often expected to lift patients from

from their beds and place them in wheelchairs or stretchers. Very often they will be responsible for conveying patients to the operating theatre.

Domestics

It is of paramount importance that hospitals are kept clean. It is essential that patients and staff are free from cross-infection. It might be assumed that anyone can keep a hospital clean and hygienic but people who express this view do not appreciate the complexities of the various wards and work units that constitute a hospital. The skills and understanding required to keep a ward or an operating theatre clean might not demand a great deal of technical skill from the domestics, but they certainly need a sound knowledge of the peculiar needs of the various wards and other units which provide the treatment and therapeutic milieu for the welfare of patients.

The women who are responsible for the cleaning tasks in hospitals were once described as cleaners, then they were given the title of domestics and, in 1970* they were classified as housekeepers. Whatever title is used to designate their occuaptional role in the hospital, they have always occupied the lowest position in the occupational structure of hospitals. It is also worth noting that the vast majority of domestics are permanently based on the lowest grade of the 18 pay groups which categorise the national rates of pay for ancillary workers in the hospital service. Whilst the NHS has a policy of equal pay for male and female, it needs to be stressed that domestics are predominantly female ancillaries and they constitute the largest of the many occupational groups of ancillary worker in the hospital service. It is also significant that there are no male ancillaries

* Designation given in University of Wales Hospital, opened in 1970

in group 1 and the only other group of ancillaries in it are the catering assistants, another predominantly female occupation.

Whilst the domestics are perceived to be women employed on the manual low status jobs associated with cleaning, they are often regarded as people who come into contact with patients. The work that is now the responsibility of the domestic or housekeeper has its roots in two previous ancillary occupations. These were the cleaners and the ward orderlies. The ward orderlies were involved in the cleaning tasks in the hospital wards and were directly or indirectly responsible to the ward sister or matron. The cleaners were involved in cleaning most of the other work units and residences in hospitals and were responsible to a domestic superintendent or to another ancillary supervisor. In the 1960s, the ward orderlies job was phased out and some of their tasks were assigned to the auxiliary nurses: making the beds, looking after the water jugs. Those tasks concerned with cleaning lockers, floors, kitchens and dishes were given to the cleaners who became domestics and, finally, housekeepers.

Maintenance craftsmen

These ancillary workers are mechanical, electrical and construction craftsmen. They maintain the mechanical and electrical equipment in the hospital service. Or they are construction craftsmen who maintain the hospital buildings. The job specifications of craftsmen demand high standards of craftsmanship. At the top end of the craft spectrum, maintenance workers are expected to understand the complexities of the mechanical and electrical systems in hospitals. At the lower end, they are expected to undertake unsupervised routine and minor repair tasks.

Maintenance fitters are responsible for maintaining the machinery and equipment in the hospital laundry. They maintain the heating systems of the hospitals. Maintenance electricians maintain the lighting and undertake such tasks as repairing the radios and televisions in the wards or rest rooms.

Building craftsmen can lay a hospital floor and ensure that it is safe for patients and others to walk on. The painters will decorate the wards, rest rooms, offices, workshops and operating theatre. The plumbers will attend to the sluices, maintain the drainage system and be responsible for the supply of water throughout the hospital.

These are but a few illustrations of the many tasks entrusted to the maintenance craftsmen and their assistants. It is clear that they provide the essential support for doctors, nurses, para-medicals as well as for administrative staff. In most hospital situations they are not in such close contact with the patients as other ancillaries. But they are aware that their work is related to patient care. Typical comments expressed to me by some of the ancillaries I talked to, were:

Electrician : "When I am repairing a radio that doesn't work I know I am being useful".

Painter : "If you're doing a job in the ward you are aware that it helps the patient".

Fitter : "I maintain some of the beds that disabled patients have to lie on and I am aware that I am helping them".

It is evident from the descriptions of the various ancillary occupations, that some of them offer considerable scope for intrinsic

involvement in work. Theatre assistants, ambulance workers and maintenance craftsmen fall into this category. But one factor that is common to all groups is the relationship of their work to patient care.

Intrinsic involvement in ancillary work

I have described the characteristics of the occupational groups of the ancillary workers that I am interested in. I will now consider the extent to which they express the first and second values of personal service orientation.

The findings of the sociologists who studied the work role of nurses found that the components of the three values of personal service orientation were of some relevance to their role. But their findings also stressed the importance of other considerations. They recognised that workplace participation was a relevant component of intrinsic involvement in work and this finding suggested that the first value as defined by Halmos[3] should be broadened to include this component. Their findings also suggested that the concept of concerned empathy defined by Halmos[4] was not entirely appropriate to the role of all caring workers, and in some respects was too demanding. In view of these findings, I intend to modify the definitions of these two values when I focus upon the role of the ancillary workers. I also hope to demonstrate that the components of this broader definition of the first value are similar to the components of intrinsic involvement in work, identified by sociologists who have studied industrial organisations (Blauner[5] and Goldthorpe *et al.*[6]).

Before we consider the way in which ancillaries were involved

in their work, I would like to make two points concerning the considerations that influenced them to take their hospital job. Firstly, I established that the advice given by relatives and friends was of particular importance. Of the 163 ancillaries who responded to the question concerned with job guidance, 40% referred to this source. It was also interesting to note that 60% of the domestics were influenced in this manner. This finding substantiates the importance of this source of advice recognised by other sociologists; Marsh and Willcocks[7], in their study of young nurses and Coghill[8] and Dale[9] in their study of ancillaries.

The second point concerns the nature of the expectations that ancillaries had about hospital work. If we refer to Table 2, we can note the relative importance that they attached to extrinsic and intrinsic considerations.

TABLE 2 .

THE MOST IMPORTANT CONSIDERATION THAT INFLUENCED ANCILLARIES TO TAKE A HOSPITAL JOB

	OCCUPATIONAL GROUPS					
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)	
	PERCENTAGING TO COLUMN TOTALS AS A BASE					
JOB CONSIDERATION	%	%	%	%	%	
Security	27	24	53	38	76	
Job near home	8	2	3	25	5	
Interesting tasks	38	43	13	26	14	
Helping people	8	29	28	9	5	
Other	19	2	3	2	0	
	100	100	100	100	100	
Number of ancillaries responding (=100%)	25	44	34	45	21	169

$X^2 = 21.3$ C = 0.33 significant at 0.1 for d f 4

Note the degrees of freedom have been determined by the adjustment to cells (see appendix 2).

I will now consider the reasons why the ancillaries in this investigation chose to work in a hsopital. Were they mainly interested in intrinsic considerations, such as a 'job with interesting tasks' or a 'job concerned with helping people'? Or were they expecting a job with such extrinsic rewards as 'a job with security' or a 'job near home', or a 'job with a good income'? The responses to these questions that relate to the work expectations of the ancillaries are presented in Table 2. This table shows that most of the ancillaries chose their jobs for extrinsic considerations. The most important expectation for the male ancillaries was 'job security' and for the females it was 'a job near home'. It is, however, interesting to note that a minority valued the intrinsic aspects of hospital work and these ancillaries were, in the main, theatre assistants. It is also of some interest to note that the ancillaries who were advised by their relatives or friends to take a hospital job were more inclined to emphasise the extrinsic factors as reasons for applying for a hospital job. We should, however, appreciate that people might want a job for extrinsic reasons but will become attached to it because of the intrinsic satisfactions they experience in their work. In view of the importance that Halmos places upon experiences of caring work as a source of satisfaction, it is important to consider the extent to which the ancillaries valued the intrinsic aspects.[10]

I wanted to find out if any of the ancillaries found the intrinsic aspects of their work to be more satisfying than the extrinsic ones. I presented the ancillaries with seven aspects of their work which were possible sources of satisfaction. Three of the aspects covered

the intrinsic satisfactions, four of the aspects covered extrinsic satisfactions. I also invited the ancillaries to indicate any other aspect of their job that they considered to be a source of satisfaction. The ancillaries who ranked two of the intrinsic considerations as the most important sources of satisfaction were considered to express a high degree of intrinsic satisfaction. Those who ranked two of the extrinsic considerations as the most important expressed a low degree of intrinsic satisfaction. Those who selected one extrinsic and one intrinsic consideration were defined as ancillaries expressing medium degree of satisfaction. In Table 3 below we can consider the nature of the satisfactions that appealed to the ancillaries. We can also consider any variation between the five occupational groups relating to these satisfactions.

TABLE 3

THE MOST SATISFYING ASPECT OF THE ANCILLARY WORKERS' JOB

	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
SOURCES OF SATISFACTION	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Helping people	71	50	56	30	0
Interesting people	0	4	10	16	0
Interesting tasks	12	32	15	6	22
Working conditions	0	3	4	6	44
Good companions	0	2	0	12	0
Secure job	17	9	11	10	33
Good pay	0	0	4	20	0
Other	0	0	0	0	0
ALL	100	100	100	100	100
Ancillaries responding (0 100%)	24	44	39	48	18

$X^2 = 36.3$ C = 0.42. Significant at 0 01for d f 4

The vast majority of ancillaries indicated that they were directly concerned with helping the patients. This suggests that they defined their work as being meaningful. If we refer to Table 4 below we can note that a majority of the ancillaries in four of the occupational groups perceived a direct helping relationship with the patients. The only exception was the maintenance craftsmen.

TABLE 4

THE ANCILLARY WORKERS' PERCEPTION OF THEIR CONTRIBUTION TO PATIENT CARE

	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n =	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
DO YOU THINK YOU ARE HELPING PATIENTS DIRECTLY IN YOUR WORK?	PERCENTAGES TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Often	88	84	72	79	30
Sometimes	8	14	21	17	53
Rarely	4	2	7	4	5
Never	0	0	0	0	0
No contact	0	0	0	0	12
	100	100	100	100	100
Ancillaries responding (= 100%)	26	44	39	49	17

$X^2 = 19.6$ C = 0.32 Significant at 0.01 for d f 4
(adjustment to cells)

When I described the nature of the work of the ancillaries in the five occupational groups, I argued that ambulance workers, theatre assistants and craftsmen required more skill and knowledge than porters and domestics. I also noted that the former three groups received some form of training. Ambulance workers and theatre assistants have been trained in the hospital environment but the craftsmen were trained, in the main, in industrial organisations. In view of the variation

in the form of work preparation it will be interesting to consider the extent to which the ancillaries had scope to find their work interesting and challenging and express what Blauner[11] defined as 'self realisation'. It can be appreciated that one can derive satisfaction from helping patients, but we need to know if they found the work interesting and challenging. In Table 5 below the perception of the ancillaries concerning the degree of self realisation they experienced in work are presented.

TABLE 5

THE DEGREE OF SELF REALISATION THAT ANCILLARIES EXPRESSED IN THEIR WORK

DEGREE OF SELF REALISATION	OCCUPATIONAL GROUPS					
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTMEN (n = 21)	ALL ANC. (n = 181)
	PERCENTAGING TO COLUMN TOTALS AS A BASE					
	%	%	%	%	%	
High	46	47	31	41	38	
Medium	38	40	38	36	33	
Low	16	13	31	23	29	
	100	100	100	100	100	
Ancillaries responding (= 100%)	26	43	36	47	21	

$X^2 = 5.82$ $C^2 = 0.19$ Not significant at 0.05 for d f 8

It is evident from the above table that theatre assistants had marginally higher self realisations scores than the other groups, but the ambulance workers were not far behind them, neither were the domestics. One has to appreciate the differences between these groups by considering the perceptions that people place upon work interest and the use of abilities. A domestic might place less value upon these variables than ambulance workers. This might suggest that male

ancillaries place more value on these intrinsic factors than women, a point made by Beynon and Blackburne.[12]

There are two further important points that can be gleaned from this table. Firstly, it is worth noting that although theatre assistants were more closely involved with medical and nursing groups than ambulance workers, they had similar self realisation scores. This suggests that the nature of the occupation might be just as important as a determinant of self realisation as the support of the personal service professionals. The second point concerns the theatre assistants. These theatre assistants were drawn from three groups of hospitals. The first group came from the large teaching hospital, a second group came from a very old medium-size hospital and a third group came from a number of smaller hospitals in the locality. It is reasonable to assume that the theatre assistants in the teaching hospital would work in a more supportive work environment than the other assistants and this would be reflected in higher self realisation scores. I established that there were no significant differences between the scores on self realisation between these three sub-groups.

One can appreciate that work can be meaningful and interesting but one needs to have scope in a supportive work situation to use one's abilities and Halmos[13] maintained that the personal service professionals would provide this support. In this investigation I focussed upon the relationship between the expression of self realisation and the degree of support from medical and nursing groups. I wanted to find out if theatre assistants received more support from the medical and nursing groups than the other ancillaries. I

also wanted to know if this support was closely associated with the expression of self realisation. I focussed upon two indicators of medical and nursing support. The first indicator was the perception that ancillaries had of the appreciation expressed by medical and nursing groups. The second indicator that I considered was the perception that ancillaries had of their relationship with medical and nursing groups.

I found that for each of the occupational groups who were directly or indirectly involved with patient care, there was no close relationship between the variables that I have referred to and there were no significant differences between the occupational groups. This is illustrated in Tables A1 and A2 in Appendix A.

It may be appreciated that ancillaries might well perceive their relationships with professional groups as one of dependence. I considered it to be relevant to this study to consider the extent to which ancillaries exerted any influence upon workplace decisions which might enable them to develop their interests and abilities in their work.

In the preceding pages, I have discussed the responses of the ancillaries to those work activities that are directly related to the components of the first value of personal service orientation and also concepts of intrinsic involvement in work recognised by many industrial sociologists. I will now consider another component of intrinsic involvement in work that many industrial sociologists have recognised, namely the component of workplace participation. Halmos does not refer to this component but, in my view, it is relevant to the first value of personal service orientation because

it is closely linked with the other components of this value.*

In Table 6 below, we can note the responses of the ancillaries to two groups of questions related to workplace participation. The first group of questions focused upon the extent to which ancillaries were consulted by their supervisors on workplace matters. The second group focused upon their perception of the extent to which they could influence their managers' decisions on matters relating to their workplace.

TABLE 6

THE DEGREE OF WORKPLACE PARTICIPATION EXPERIENCED BY ANCILLARIES

DEGREE OF PLACE PARTICIPATION	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
High	4	10	5	8	15
Medium	46	51	50	36	60
Low	50	39	45	56	25
	100	100	100	100	100
Ancillaries responding (=100%)	26	39	38	39	20

X^2 7.35 C = 0.21 Not signficant at 0.05 for d f 4

It is evident from the data in Table 6 that only a small minority in each of the groups exercised a high degree of influence on work-place decisions. It is, however, interesting to note that the theatre assistants who worked closely with medical and nursing groups appeared to be less influential than the craftsmen. The findings suggest

* the scores are based on the combined responses to questions 29 and 30 in the questionnaire (see Appendix C).

that the personal service professional culture does not encourage theatre assistants to participate in the decisions that relate to the operating department.

I am arguing the case that the ancillary workers who had high scores on the four components that I have referred to can be defined as workers who expressed the first value of personal service. They would also be recognised by industrial sociologists as workers who were intrinsically involved in their work.

I will measure the expression of the first value by drawing upon the data in Tables 3, 4, 5 and 6. I will compute the mean average score for each occupational group for each of the components. I will then compute the weighted mean average for the four components for each occupational group. I will be particularly interested in comparing the scores of the theatre assistants with the other occupational groups.

TABLE 7

THE FIRST VALUE OF PERSONAL SERVICE ORIENTATION: INTRINSIC INVOLVEMENT IN WORK, EXPRESSED BY ANCILLARY WORKERS

OCCUPATIONAL GROUPS: MEAN AVERAGE SCORES

THE COMPONENTS	AMBULANCE (n = 25)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)	ALL (n = 181)
Meaningful work	1.09	1.13	1.34	1.43	2	1.31
Instrinsic satisfaction	3.8	3.8	4.51	5.4	5.5	4.49
Self realisation	3.2	2.7	2.97	2.8	2.9	2.88
Workplace particip:	4.7	3.9	4.5	4.6	3.8	4.26
Total score	12.79	11.53	13.32	14.23	14.2	12.97

F = 7 Significant at 0.01 for d f 4 and 149

It is evident that there is a significant variation in the scores of the four groups and the theatre assistants expressed the highest score. I also tested the variation between three age groups and found no significant difference between them. This* suggests that there is some support for the Halmos[14] hypothesis that ancillaries most closely involved in the personal service professional culture are more personal service orientated than other ancillaries. One should not, however, draw this conclusion without considering other factors.

I noted that there was no close relationship between medical and nursing support and high self realisation for theatre assistants. It is possible that the theatre assistants who were the most intrinsically orientated of all the ancillaries, a fact noted in Table 2, were strongly motivated to establish themselves in a position where they would overcome any difficulties due to a lack of professional support.

The data in the four tables referred to in this chapter indicated a number of statistically significant variations relating to the intrinsic aspects of involvement in work. The theatre assistants differed in respect of their intrinsic expectations from most of the other groups and they were more intrinsically orientated than the other ancillaries. The ambulance workers and theatre assistants also varied significantly from the other ancillaries in respect of their intrinsic satisfactions. There was also a significant variation in respect of the meaningful patient orientated aspect of their ancillary work, with the craftsmen indicating that this perception was not as

* See Tables A4 and 5 in Appendix A

strongly expressed by them as it was with the other four groups.

When considering the degree of self realisation, which might be regarded as the core component of intrinsic involvement (or the first value of personal service orientation), no significant variation was found between the five ancillary groups. Neither was there a significant difference in respect of the degree of workplace participation expressed by the ancillaries.

When I measured the overall degree of intrinsic involvement (which I also defined as the first value of personal service orientation), I established that there was a significant variation between the groups and that the most pronounced differences were between the theatre assistants and the domestics and craftsmen. One can appreciate that the craftsmen were not so closely involved with the patients as the other groups were and that their intrinsic satisfactions were limited to the task aspects of their work, with limited opportunities for satisfactions through helping patients. This consideration should also apply to the meaningful helping aspect of their work which was directly concerned with helping the patients.

The considerations that related to the craftsmen did not, however, apply to the domestics and this could suggest that the women employed in this work were less intrinsically involved than the men. In this respect they tend to conform to the women in industrial situations that Beynon and Blackburn referred to in their studies[15].

Concerned empathy in ancillary work

I have established the extent to which ancillaries expressed

the first value of personal service orientation but I will not examine the extent to which they expressed the second value, defined by Halmos[16] as 'concerned empathy'. Halmos stressed that concerned empathy was based on the "dispassionate yet maximally sensitive empathic consideration of the clients' needs". In my view, this definition is too demanding for ancillaries who fulfil a supportive role for medical and nursing groups, and a less demanding definition is more appropriate. It is reasonable to argue that ancillaries can empathise with patients without establishing close personal relationships. If they are capable of responding to the patients' needs by providing the type of warmth and possibly care that Bramner[17] described, then they will provide the degree of emotional support recognised by the Central Health Services Council that I referred to in page 111.

I established that, out of the 147 ancillaries who indicated the degree to which they wanted to know patients, 49 (33%) of them either knew the patients well or wanted to know them well. This suggests that many ancillaries wanted to empathise with the patients. If we refer to Table 8, we can appreciate this interest.

TABLE 8

THE DEGREE TO WHICH ANCILLARIES KNOW OR WANT TO KNOW PATIENTS

	OCCUPATIONAL GROUPS				
KNOWING PATIENTS	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 49)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Know most	23	3	14	13	6
Like to know	36	11	27	7	12
Not really	38	39	27	17	6
Not relevant	3	47	32	63	76
Ancillaries responding	100	100	100	100	100
	26	38	37	46	17

χ^2 [illegible] Significant [illegible]

It is evident from the data in Table 8 that only in two of the occupational groups is there a substantial proportion who either know patients well or want to know them well. This variation in attitudes might be attributed to the nature of the relationships between the occupational groups and patients. One can appreciate the position of the theatre assistants, who mainly come into contact with patients in a stressful situation when they are helping to prepare these patients for an operation. In this situation, they will be part of a team providing emotional support. They are not usually involved with the patients in the recovery ward because this work is clearly defined as a nursing responsibility.

The other occasions when theatre assistants come into contact with patients is when patients have prolonged surgical treatment such as the insertion of heart pacers in coronary care situations. Only in this type of situation can theatre assistants establish close personal relationships with the patients.

In the case of craftsmen, they rarely come into contact with patients and are not expected to provide the degree of emotional support expected from ancillaries who are in direct and frequent contact with them. Their responses to the question on knowing patients, clearly indicates that they do not consider knowing patients to be relevant to their work.

It is, however, interesting to note that the vast majority of domestics did not consider knowing patients to be relevant to their work, whilst porters and ambulance workers did consider it relevant. This variation might be attributed to the fact that domestics work

far more closely with nurses in the ward situation and they might be more reluctant to talk to patients when nurses are present. The responses to the question concerning the degree to which domestics were encouraged by nurses to talk to patients indicated that only 6 out of 37 domestics who responded to this question indicated that they were encouraged by nurses to talk to patients.

Whilst porters were also in a similar position with only 6 out of 39 indicating that they were encouraged to talk to patients, they were more frequently involved with patients outside the ward situation. They could be conveying patients to X-Ray or to the physiotherapy unit and, in these situations, they would be more inclined to talk to patients.

The fact that the vast majority of ancillaries were not encouraged to talk to patients by nurses is an interesting point. It suggests that talking to patients is a very serious business in certain hospital situations and nurses are entitled to be concerned about the nature of the information exchanged between non-professionals and patients. This further suggests that the type of emotional support provided by ancillaries should be contained within the structure of a caring team, controlled by the medical and nursing professionals. Involvement in a caring team to provide some degree of emotional support would require some degree of training for ancillaries to enable them to empathise with patients effectively. Ancillaries should be aware of the dangers that might arise if they enter into conversations with patients which can arouse anxiety. The low response to the question concerned with knowing patients

might well indicate that some ancillaries were aware of the strain they might experience by establishing close personal relationships with patients.

It is also interesting to note that there was no close association between the expression of the first value and the expression of the second value of personal service orientation. Some ancillaries in the portering and domestic occupational groups expressed a strong interest in knowing patients but they had a low degree of intrinsic involvement in work. Whilst theatre assistants expressed a high degree of intrinsic involvement, they were not interested in knowing the patients. If we identify the ancillaries who expressed a high degree of intrinsic involvement in work and who wanted to know the patients well, only 23, or 10%, were in this category.

Summary

In this chapter, I described the nature of the work of five ancillary occupational groups in the hospital service. I also examined the expectations that ancillaries brought to their work. I established that the majority of these workers were predominantly interested in extrinsic considerations with job security being of particular importance. I also noted that the theatre assistants were more intrinsically orientated than the other ancillaries. I then examined the extent to which ancillaries were intrinsically involved in their work and, in particular, whether or not this form of intrinsic involvement in work was similar to the type of work

involvement that Halmos referred to when he defined the first value of personal service orientation.[18] I made the point that, if I included the component of workplace participation with the three components of the first value defined by Halmos, then we would have a broader definition of the first value that should satisfy the Halmos criteria and the criteria of industrial sociologists[19].

I was particularly interested in comparing the theatre assistants with the other ancillaries. The theatre assistants had closer working relationships with medical and nursing groups then the other ancillaries and, in the context of the Halmos hypothesis should be more personal service orientated than the other groups because they are likely to benefit from professional tutelage and support[20].

I found that there were no significant differences between the scores of the ancillaries on the three of the four components of the first value. Most of the occupational groups had high scores on the meaningful work component. Most had low scores on the workplace participation component and most had medium scores on self realisation. The most pronounced differences were on the intrinsic satisfaction component with ambulance workers and theatre assistants having the highest scores.

I also established that the theatre assistants in the old medium-size hospital had a higher intrinsic involvement score than their colleagues in the other hospital.

I also focused upon the relationship between self realisation (one of the components of intrinsic involvement) and professional support. I found no close association between self realisation and professional support for any of the occupational groups.

I concentrated upon the interest which ancillaries had in 'knowing patients', which Halmos considered to be relevant to 'concerned empathy'[21] and I found a significant variation between the groups. I found that theatre assistants were less interested in knowing patients than were the other groups. Whilst this finding does not lend strong support to Halmos' argument about 'concerned empathy', it does suggest that there are certain characteristics in hospital occupations which inhibit the close personal relationships envisaged by Halmos.[22]

In the next chapter I will examine in some detail the relationships between ancillaries with medical and nursing groups. The nature of this relationship is relevant to the third value of personal service orientation defined by Halmos as 'professional integrity.[23] If ancillaries express the first or second value of personal service orientation and are supported by medical and nursing groups, then this should nurture the type of integrity that Halmos defined.[24] I will be particularly interested in the relationships between nurses and ancillaries. Nurses, in my view, are more likely to be perceived as a reference group than the medicals for those ancillaries who look for professional support, because nurses are more closely involved with ancillaries than are the medicals.

CHAPTER FOUR

THE ANCILLARY WORKERS' INVOLVEMENT IN THE PERSONAL SERVICE PROFESSIONAL CULTURE

Relationships between ancillaries with medical and nursing groups

I have described the extent to which ancillaries expressed the first and second values of personal service orientation in chapter three. I will now consider the extent to which they express the third value. I will argue in this chapter that ancillaries who were firmly supported by medical and nursing groups, would be encouraged to maximise their contribution to patient care. If they receive the type of tutelage and support that Halmos[1] envisaged, then ancillaries would express the third value defined as occupational integrity.

In this chapter I will examine the ancillary workers' perception of their relationships with consultants and other doctors. I will then examine their perception of their relationships with senior nurses and other nurses. First, I will analyse the responses of the ancillaries to questions relating to their relationships with these predominantly professional groups. Secondly, I will illustrate the nature of the ancillary's perceptions by quoting specific observations that were made to me when I interviewed a cross-section of them in their particular hospital, or occasionally in a group situation.

The importance of reference groups in the socialising process in work cultures has been recognised by Shibutani[2]. In the context of the Halmos[3] hypothesis concerning personal service professional socialisation, professionals should be models of occupational behaviour in a caring

service. They should set the standards, norms and values, which should inspire ancillary workers and integrate them into the professional work culture of hospital organisations.

In the context of this study, it is reasonable to assume that theatre assistants should receive much more support from medical and nursing groups than other ancillaries and it will be interesting to see if this is the case.

Relationships with consultants and other doctors

If we refer to Tables 9 and 10, where I tabulate the responses of the ancillaries to two questions relating to their perceptions of medical appreciation of their contribution to patient care, it is quite evident that the theatre assistants were the most involved group with their favourable attitudes towards consultants, with the least involved group being the domestics, with their more negative and unfavourable attitudes. The contrasting attitudes also apply to to the other doctors, although there is a marginally more favourable perception towards this group of medicals by all of the ancillary groups. These attitudes are illustrated in Tables 9 and 10 below.

TABLE 9

ATTITUDES TOWARDS THE APPRECIATION OF CONSULTANTS

DO YOU THINK YOUR WORK IS APPRECIATED BY CONSULTANTS?	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Yes	71	79	71	30	38
No	3	4	17	7	56
Don't know	26	17	12	63	6
Ancillaries responding (100%)	100	100	100	100	100
	24	42	34	27	14

$X^2 = 22.7$ C = 0.37 Significant at 0.001 for d f 4*
(* adjustment to cells)

TABLE 10

ATTITUDES TOWARDS THE APPRECIATION OF DOCTORS

DO YOU THINK YOUR WORK IS APPRECIATED BY DOCTORS?	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (b = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Yes	76	86	55	36	41
No	12	2	13	7	54
Don't know	12	12	32	57	5
Ancillaries responding (100%)	100	100	100	100	100
	25	41	31	28	17

$X^2 = 23.6$ C = 0.38 Significant at 0.01 for d f 4*
(* adjustment to cells)

Relationships between ancillaries and medicals were illustrated by the comments ancillaries made about them. A theatre assistant said, "I got to know consultants quite well and they got to know me, but occasionally the anaesthetist and surgeon get upset and they have given me a rollicking, but if I took too much notice of these outbursts I would have packed up the job a long time ago. *Mind you, I wouldn't put up with that* in *another job*, but I realise the special strains that these men work under".

Theatre Assistant

"You get to know the temperament of the consultant over a period and we try to adapt to this. So I have got on with all of them over the 30 years I worked with them".

Theatre Assistant

"If an anaesthetist loses his temper or criticises you, you don't argue back, you will never win. But we get to know each other".

Theatre Assistant

"If the consultant thinks you are interested in the technical

side of his work he will take the trouble and time to explain to you about the type of operation and the way he is dealing with it".

Domestic

"We have very little to do with consultants. If they enter the ward we will leave quickly".

Domestic

"We try to prepare the ward and complete our main work before the doctors and consultants do their rounds, so we can be out of the ward when they arrive".

Domestic

"We rarely come across the doctors in our work".

Domestic

"One comestic I knew had a nasty experience. She was rattling dishes when a doctor was in the ward. He looked hard at her and she dropped the dishes. She was never the same for some time afterwards".

Porter

"We often come into contact with consultants and they seem to appreciate us".

Porter

"We meet consultants and doctors in the casualty ward and we get on with them".

The theatre assistants were much more involved with consultants and doctors than the other ancillaries were and these professionals can justifiably be regarded as an important reference group for

theatre assistants, particularly in the context stressed by Halmos[4] about professional support.

It has been well established that the work in the operating department is one of the best examples of a highly committed work force directing shared energies to a well-defined common purpose. Indeed, one esteemed industrial psychologist referred to the operating department team as an example of all that is best in team work that cuts across social divisions in a work situation (Cooper[5]).

The strong sense of common purpose has also been stressed by nurses and this extract from an article by Gay McInnes, a senior theatre nurse, in a New Zealand nursing journal, illustrates this view,

> The atmosphere of concentration is centred at the operating table. There is a great deal of high powered business going on in there. Years of training and learning are being concentrated on one particular human being. A deeply unconscious human being who is utterly and completely dependent upon the knowledge, skill and experience of the surgical team surrounding him; his survival is at stake and he cannot protect himself, express pain or comfort; he cannot defend his rights"
>
> and
>
> When as a fully integrated team, we move into action quietly knowing this is the most or possibly the most crucial point of this particular patient's stay in the hospital he is totally dependent on our skill and training ..."[6]

In view of the nature of the supporting role of theatre assistants in such a team, we can appreciate that theatre assistants have a more favourable perception of their relationships with the medicals than other ancillaries. But other ancillaries also provide important background support and they might want to obtain some

degree of appreciation for their work.

It is conceivable that one of the contributory causes of the uncertainty expressed by ancillaries about the consultants' appreciation of their role can be attributed to the distance between certain occupational groups and consultants in their work, and possibly the wider social distance between the high status consultants and the low status ancillaries. The degree of contact between most ancillaries and consultants was low and often such contact was mediated through a third person, such as a nurse. The only ancillary group that had an affirmative view of consultants appreciating their role were the theatre assistants. This was probably due to the close relationship that this group had with the consultants with whom they worked as members of an intensive care ward. There were, however, many comments expressed by the theatre assistants with whom I talked, that consultants did not fully appreciate them. One theatre assistant said, "I often wonder if consultants appreciate the pressures that we work under" and "I don't know if the consultants are aware of our working conditions".

It is also conceivable that the different perspectives between the theatre assistants and the domestics reflect the different degree of communication between them and such reference groups as doctors and consultants. The theatre assistants are in close physical contact with consultants, doctors and nurses and are indirectly involved in group co-operation with them on a shared task of operating upon a patient.

The domestic work is very remote from the doctors and consultants

and communication between these groups often exists only indirectly. Conversation may not take place between a doctor and a domestic and the domestic may infer the doctor's attitude towards her work only from such overt behaviour as a smile of recognition when entering the ward, or the usual common courtesy that one might expect from one citizen to another.

Most sociologists interested in hospitals would agree that the general and most normative commitment that is predominant in hospitals is 'caring for the patients'. One of the major sources of this commitment should be the values of the professional groups that exercise most influence in the hospital. It is reasonable to argue that if the supportive ancillary groups co-operate with these professionals to achieve this major goal of patient care, then this will indicate that the role of professionals and non-professionals are in congruence.

It could be argued that the intensity of this commitment to patient care can vary from individual to individual, or with each occupational group. Each occupational group can bring its own perceptions to bear upon the general values of the hospital sub-culture and will interpret their obligations in their own particular way. In the context of the hypothesis relating to personal service orientation the groups that work most closely with the medical and nursing professionals should be more responsive to their leadership role relating to their norms and values.

The involvement of the theatre assistants with medical and nursing groups is closer than that of the domestics. Indeed, the

theatre assistants are an integral part of the operating department team. This team cuts across professional and non-professionals and draws its members from diverse occupational groups, embracing the consultants at one end of the spectrum and the theatre assistants at the other. It is reasonable to assume that normative behaviour of the theatre assistant is more sensitive to the socialising influences of the professional groups than the domestics, who have a looser and more marginal relationship with the professionals. This view is supported by the data in Tables 9 and 10, which show a greater degree of role involvement between the assistants and professionals than that which prevailed for domestics.

Another contributory factor, which helps to cultivate a strong commitment to organisational goals for certain occupational groups, is the attitudes which can be generated by occupational groups searching for a new occupational identity. Groups which are working for professional status will be more sensitive to the value of those professionals, that they accept as model reference groups, than those groups without such aspirations. Theatre assistants and ambulance men are two occupational groups who clearly perceive themselves as para-medical groups. Not only do they work with these professionals, but they are also being trained by consultants, doctors, nurses, to acquire the knowledge required for their new role.

Theatre assistants are taught and trained by the anaesthetist, consultant and nurses on the job. They will also attend formal courses where they will be instructed by these professional groups. These professionals will not only impart knowledge and skills but they will also teach the professional values concerning relationships with

patients and will stress the ethical commitment to them. In this context, part of the socialising influence that the theatre assistants experience at work, is under the control of the professional. To some extent the ambulance workers are also taught and instructed by medical groups and they also experience elements of professional socialisation.

Domestics, unlike these other groups, are not involved in a change in their occupational status and we can appreciate that they are not prepared in their work role by formal and informal training of professionals. We can also understand that they might be less influenced in their work role by the standards and values of professional groups. We should, however, appreciate that their close involvement with nursing groups is a source of normative influence which will reflect professional values.

TABLE 11

THE DEGREE TO WHICH ANCILLARIES MEET NURSES IN THEIR WORK

	OCCUPATIONAL GROUPS				
HOW OFTEN DO YOU MEET NURSES IN YOUR WORK?	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Every day	88	85	94	78	47
Occasionally	12	15	6	17	14
Never	0	0	0	5	39
ANCILLARIES	100	100	100	100	100
RESPONDING (= 100%)	25	45	35	47	18

$X^2 = 14.8$ C = 0.29 Significant at 0.01 for d f 4*

(* adjustment to cells)

TABLE 12

THE DEGREE TO WHICH ANCILLARIES GOT ON WELL WITH NURSES

HOW WELL DO YOU GET ON WITH NURSES?	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Get on well with all	27	40	36	29	24
Get on well with most	70	45	51	67	66
Get on well with some	3	6	13	4	10
Don't get on well	0	9	0	0	0
ANCILLARIES	100	100	100	100	100
RESPONDING (= 100%)	23	44	39	45	21

$X^2 = 2.09$ C = 0.29 Not significant 0.05 for d f 4*

(* adjustment to cells)

It is evident from the above tables that most groups were closely involved with nurses in their work, the group with the lowest degree of involvement were the craftsmen. All ancillaries had a much closer working relationship with nurses than they had with consultants and doctors and most ancillaries got on reasonably well with nurses.

Whilst I have established the extent to which ancillaries got on well with nurses, it is important to understand the extent to which they were appreciated by nurses and were encouraged by them to help patients. Appreciation and encouragement by nurses can certainly be regarded as important indicators of professional socialisation in the work culture of hospitals. I invited the ancillaries to respond to questions concerning their perception of the appreciation

of senior nurses, who represented nursing sisters and nursing officers and other nurses, who represented State Registered and State Enrolled Nurses. Their perception of the nurses' appreciation is presented in Tables 13 and 14.

TABLE 13

ATTITUDES TOWARDS THE APPRECIATION OF SENIOR NURSES

	OCCUPATIONAL GROUPS				
DO YOU THINK YOUR WORK IS APPRECIATED BY SENIOR NURSES?	AMBULANCE (n = 21) %	THEATRE (n = 45) %	PORTERS (n = 50) %	DOMESTICS (n = 39) %	CRAFTSMEN (n = 21) %
Yes	71	79	71	55	53
No	4	4	17	11	13
Don't know	25	17	12	34	34
ANCILLARIES	100	100	100	100	100
RESPONDING (= 100%)	24	42	34	38	14

$X^2 = 7.1$ C = 0.21 Not significant at 0.05 for d f 4*

(* adjustment to cells)

TABLE 14

ATTITUDES TOWARDS THE APPRECIATION OF OTHER NURSES

	OCCUPATIONAL GROUPS				
DO YOU THINK YOUR WORK IS APPRECIATED BY OTHER NURSES?	AMBULAND (n = 26) %	THEATRE (n = 45) %	PORTERS (n = 39) %	DOMESTICS (n = 50) %	CRAFTSMEN (n = 21) %
Yes	76	75	74	64	62
No	8	9	6	7	6
Don't know	16	16	20	29	31
ANCILLARIES	100	100	100	100	100
RESPONDING (= 100%	25	43	35	42	16

$X^2 = 2.08$ C = 0.11 Not significant at 0.05 for d f 4*

(* adjustment to cells)

Relationships with nursing groups

I will now consider the relationships that prevailed between ancillaries and nursing groups. I will consider the extent to which ancillaries vary in terms of the extent to which they work with nurses. I will consider the nature of their relationships with nurses. I will establish the extent to which they get on well with nurses. I will consider the extent to which they believe that nurses appreciate their work. I will also consider the extent to which they believed they were encouraged to help patients.

I will be interested in establishing the extent to which ancillaries worked in a supportive work situation. In view of the fact that nurses work with most ancillary workers in the various occupational groups, then it is fair to argue that the nature of these relationships is of particular relevance to the Halmos[7] hypothesis concerning professional tutelage.

I will also be interested in establishing the extent to which theatre assistants enjoyed more support than the other ancillary workers. In view of the fact that they came into much closer contact with nurses than the other ancillary workers, it might well be the case that they would illustrate the type of relationship envisaged by Halmos[8] when he described the socialising influence exerted by key reference groups in the personal service professional culture.

It is reasonable to argue that nurses would represent themselves as models of occupational behaviour to those ancillaries who want to learn as much as possible about the ways and means of improving their contribution to patient care. This should apply to the theatre

assistants because they represent an occupational group, that was formed in order to help nurses and the medical groups in the operating departments of hospitals.

I will now consider the extent to which ancillaries worked with nurses. I will also consider the extent to which they 'got on with them' in their working relationship. In Tables 11 and 12 we can see the perceptions of the ancillaries concerning these relationships. It is evident from the above tables that a majority of ancillaries in each occupational group considered that senior nurses and other nurses appreciated their contribution to hospital work. It is, however, interesting to note that theatre assistants did not differ significantly from ambulance workers and porters in this respect. It is also interesting to note that only a small minority were of the opinion that they were not appreciated although a substantial minority were not sure what nurses thought about their work.

If we now consider the extent to which nurses encouraged ancillaries, we will be focusing upon the more positive aspects of the socialising influence in the caring milieu. Encouragement to help patients, suggests that nurses recognise that ancillaries are providing a contribution to patient care. It can be seen as a positive affirmation of a meaningful contribution to the welfare of the patient. The ancillary workers' perception of such encouragement is present in Table 15.

It is evident from this table that there is a differential form of involvement between ancillaries, nurses and patients. The

TABLE 15

THE DEGREE OF ENCOURAGEMENT THAT ANCILLARIES CONSIDERED THEY RECEIVED FROM NURSES TO HELP PATIENTS

	OCCUPATIONAL GROUPS				
ARE YOU ENCOURAGED BY NURSING STAFF TO HELP PATIENTS?	AMBULANCE (n = 21) %	THEATRE (n = 45) %	PORTERS (n = 39) %	DOMESTICS (n = 50) %	CRAFTSMEN (n = 21) %
Often	42	70	43	14	7
Occasionally	37	23	46	29	27
Never	21	7	11	57	66
ANCILLARIES RESPONDING (= 100%)	100	100	100	100	100
	24	44	35	44	15

$X^2 = 37.2$ C = 0.42 Significant at 0.001 for d f 4*
(* adjustment to cells)

most involved workers were the theatre assistants and the least involved were the craftsmen.

It is evident from the data in Tables 13 to 15 that most of the ancillaries had favourable relationships were nurses. These relationships suggest that there is some basis for ancillaries to have some degree of self-esteem in their work. But this does not necessarily mean that they have the type of occupational integrity that Halmos[9] referred to when he defined the third value of personal service orientation. Halmos stressed the relationship between strong support from personal service professionals and the expression of the first and second values of personal service orientation.[10] There is a need to test the strength of this relationship to validate

the Halmos hypothesis.[11]

In view of the reservations that I expressed about the relevance of the second value of personal service orientation for all ancillaries, it might be more reasonable to consider the relationship between the first value of personal service orientation, which I have broadly referred to as 'intrinsic involvement in work', with the degree of support provided by nurses.

When I examined the strength of the relationship between these variables there was clearly no significant relationship. This can be seen in Table A7 in Appendix A. This finding suggest that support from personal service professionals is not as strong a determinant of intrinsic involvement in work as Halmos envisaged[12]. When we consider this finding with the other finding concerning the relationship between self-realisation and medical nursing support that I referred to in Chapter Three, one cannot find strong evidence to support the Halmos hypothesis concerning the value of personal service professional tutelage.

Even if we focus upon the relationship between theatre assistants with nursing groups we find that there was no close association between nursing support and intrinsic involvement. Whilst those theatre assistants in the medium size hospital had more support from nurses than their colleagues in the teaching hospital, this was not reflected in a pronounced difference in the degree of intrinsic involvement expressed by both groups of theatre assistants.

I have analysed the relationships of ancillaries and nurses on a statistical basis. It will now be interesting to consider some of

of the comments of ancillaries about these relationships.

Theatre Assistant

"We get on with nearly all of the nurses, although we have some differences".

Theatre Assistant

"Years ago some of the sisters were hard and treated us like slaves but things have changed today. My present sister fights like hell to improve our conditions".

Ambulance Worker

"The nurses we are mostly in touch with are the Casualty nurses and we get on well with them".

Abulance Worker

"We get to know the nurses at the hospital and we can often get a cup of tea from them and this helps".

Domestic

"I work in the Orthopaedic Ward and I do most of the work on my own and when it gets too hard I say that I am going to ask to be transferred to another ward. Then the nurses say, 'Oh, don't go or we'll be in a mess'. Then I realise that they really appreciate me".

Domestic

"Getting on with nurses and others in the hospital makes life much more pleasant".

Unfavourable comments were also expressed by some ancillaries, particularly by domestics.

Domestic Supervisor

"Well a number of us felt out of things Christmas time. We were never given a Christmas dinner, neither did we have any decorations for our mess room".

Domestic

"I can only think of one sister that I couldn't get on with and she had an attitude towards us which showed that whatever work we did it was not appreciated. In fact I refused to work in that ward with her and left to float around the other wards until I came and settled in the Geriatric Ward".

Domestic

"I know that some domestics feel that they are not appreciated but I don't feel this way. On Christmas Day I started to wash up the dishes in the ward kitchen and sister came and insisted that I came out and had a meal with them and the doctor cut the turkey for me. I felt I was part of the team".

Domestic

"Domestics often feel that they are the bottom of the heap. Very often if a nurse or a doctor is leaving the hospital the nurses and doctors will throw a party but quite often we are left out and we feel upset about this".

Theatre Assistant

"Sometimes we feel out in the cold and we would like the top strata to come and have a look at us and see what our problems are".

Whilst the relationship between nurses and the craftsmen was not as close as that of the personal service ancillaries, good relationships

between them are important. If a nurse wants an electrician she can request one through formal procedure, but very often good personal relationships can improve such communication, and work can be done without too much procedural formality. It is vital to this relationship that the *non* personal service ancillaries feel that their indirect contribution to patient care is appreciated. A lack of appreciation will make his work meaningless and such a feeling can create a sense of separateness and isolation from the patients, nursing and other professional groups.

Some comments illustrating the craftsmens personal service ancillaries' perception of their contribution to patient care are quoted below:

Plumber

"We get on with most nurses and some of them appreciate the fact that if we didn't look after the drains and sluices the nurses would be in real trouble".

Fitter

"Our work is not always appreciated by nursing staff but we make an important contribution to the hospital".

Carpenter

"We often move around the hospital and get to know patients and nurses. It's nice to feel we count here".

Painter

"We are part of the hospital. We feel we can help patients through our work".

We can see that most of the personal service ancillaries and a

substantial minority of non personal service ancillaries felt that their contribution to the care of the patient was appreciated. Burtz, in her study of nursing aides in geriatric wards, argued that one of the sources of role strain for nursing aides "could be the lack of recognition the nurse aides receive" (from professional groups).[13] This sociologist stresses the importance of appreciation for work done by nursing aides and went on to argue that if "other personnel do not share her relative importance of the work which she does", then the aide could express resentment.

We can appreciate that recognition by the nurses for the work of the ancillaries, and good relationship between these groups, will integrate the ancillaries into the hospital team, working towards achieving a common goal.

The comments expressed by the ancillaries about their relationships with medical and nursing groups, give us some indication of the social divisions that exist in hospital situations. Most of the comments suggested an awareness of social distance between medical and ancillary work groups. Even the theatre assistants who expressed the most favourable views about their relationships, indicated an awareness of social differences. The comment expressed by one theatre assistant about the inferior welfare amenities and his belief that consultants were not aware of these conditions underlines this point. In view of the fact that consultants and other doctors have separate changing and rest rooms from theatre assistants and nurses in the hospital where this theatre assistant worked, one can appreciate how social differences in work are perpetuated.

Most of the comments relating to nurses as well as medicals, indicated the value that ancillaries placed upon their contribution to patient care, and the importance they attached to this contribution being recognised by significant others. Such appreciation is important since it can be seen as an important source of self-esteem and occupational integrity. Even if the consultant earns much more than the porter, a firm indication of appreciation and encouragement is of considerable importance.

There is, however, a need to distinguish between a paternalistic relationship and a genuine supportive relationship. A smile and a pat on the back can be very helpful. But in the context of the Halmos hypothesis, medical and nursing groups must be more positive in developing their ancillaries. The theatre assistant who made the point that his ward sister fought hard for them illustrates the type of support that Halmos anticipated.[14] The nurses who fought to promote the interests of their subordinate workers might well incur the wrath and displeasure of some their colleagues but will be appreciated by the ancillaries. A long term commitment is needed to fight for resources within the hospitals to train people such as theatre assistants up to the standards desired by nurses who are concerned about the quality of their contribution.

Summary

In this chapter I have examined the pattern of work relationships between ancillaries and medical and nursing groups. The relationships that ancillaries establish with these groups is an important part of their socialising experience in what Halmos described as the personal service professional culture.[15]

I described how most of the ancillaries had close working relationships with nurses and that nurses would represent a key reference group for those ancillaries who looked for support in the personal service professional culture. I also established that theatre assistants were more closely involved with the medical groups than any of the other ancillary groups.

The relationship between ancillaries and medical and nursing groups provide us with some indication of the degree to which ancillaries benefited from the support and tutelage that Halmos envisaged. By examining the pattern of the relationships between ancillaries and the nursing group, it is possible to test the hypothesis that theatre assistants who were the ancillaries most closely involved with nurses would have more tutelage and support from them than any of the other groups.

The responses of the ancillaries to the questions relating to their relationships with nurses were tabulated and it is interesting to note that, in the four tables that related to the support, appreciation and encouragement that the ancillaries received from nurses, there were significant variations in two of the tables. In Table 11 it was noted that craftsmen were not involved as closely

with nurses as the other four groups. But there was no significant difference in the degree to which ancillaries 'got on' with nurses (in Table 12). Neither was there a significant difference in the degree to which the five groups were appreciated by nurses for their work.

The most significant difference was illustrated in Table 15, which referred to the degree of encouragement that the ancillaries received from nurses to help patients. It is, however, interesting to note that the main variation was between the theatre assistants and the domestics and the craftsmen. If we consider the relationships that theatre assistants had with nurses, they were clearly much closer than the relationships that other groups had established with them. This suggests some degree of support for the Halmos hypotheses concerning nursing tutelage and support, although it needs to be emphasised that theatre assistants often worked closely for long periods on common tasks, in a highly demanding, challenging work environment which depended a great deal upon group co-operation and shared responsibility.

It is also important to note that there was no strong relationship between intrinsic involvement in work and nursing support and it is possible that there are other factors in the work situation that might inhibit the theatre assistants from using their personal resources fully in this work environment. It is also evident that theatre assistants were appreciated by consultants and other doctors and again, this tends to support the Halmos hypothesis concerning professional tutelage. This appreciation was also perceived by the ambulance workers but it was less evident in the case of the domestics.

In this chapter I established that the theatre assistants' perceptions of their relationships with medical and nursing groups suggests that they had a greater degree of occupational integrity and self-esteem than porters and domestics, but only marginally more than the ambulance workers.*

In the next chapter I will consider another aspect of the ancillary workers' relationships with nursing groups. I will examine the extent to which the ancillary workers experienced role strain in their relationships with nurses and in other aspects of their work. I will again be particularly interested in the position of the theatre assistants relative to the position of the other groups. I will test the hypothesis that because theatre assistants work very closely with nurses in the operating theatre, they should experience less role strain than those ancillaries who do not share this experience. If they do experience less role strain then this again would be an indication of self-esteem and occupational integrity for theatre assistants.

The data that I will refer to in the next chapter on role strain, together with data referred to in this chapter, related to the ancillaries relationships with nurses which I have examined, should provide provide a firm basis for constructing a scale that will enable us to measure the expression of personal service orientation by hospital ancillaries in their work. This data should then provide a statistical basis for testing the hypotheses presented by Halmos[16] that ancillaries who are closely involved in a personal service professional culture will develop a personal service orientation in this milieu.

* I will not include the craftsmen because of their low degree of involvement with nurses.

CHAPTER FIVE

ROLE STRAIN IN ANCILLARY WORK

In this chapter I examine the extent to which ancillaries experienced role strain in their work. In the preceding chapter I examined the nature of the relationships between ancillaries and nursing groups. In this chapter I will examine the extent to which ancillaries experienced role strain through such relationships with nursing groups. The relationships between ancillaries and nursing is very relevant to the concept of personal service orientation as defined by Halmos[1]. If ancillaries perceive favourable relationships with nurses, who represent an important reference group, then they should develop to some extent the type of occupational integrity which Halmos referred to in his third value of personal service orientation.[2]

I will also consider other aspects of role strain. I will examine the extent to which ancillaries experience strain because they believe they can do much more for the patient. I will consider the nature of the strains that ancillaries experience in their relationships with patients. In Chapter Three I established that some ancillaries did not want to develop close personal relationships with patients and I suggested that this might be attributed to the stresses and strains that can be experienced in caring occupations.

Grace argued that the "central component of all of the formulations of the concept of role strain, role conflict, or role stress are concerned with problems for the individual which arise as the result of role incompatibilities".[3]

In the discussion of the literature section of this thesis, I referred to the type of role strain that nurses experienced. It was evident that many sociologists such as Burz expressed the view that people who wanted to help and were constrained by organisational factors from helping would experience role strain.[4]

I will be interested in this chapter in examining the extent to which ancillaries vary in the type of strain experienced. I will also examine the relationship between role strain and intrinsic involvement in work. Ancillary workers in hospital organisations have to relate to a large number of people in various occupations, as well as the patients that they deal with. These people can have various expectations in respect of what they want from the ancillaries that they relate to. These expectations have to be dealt with by ancillaries, who can occasionally, or frequently, experience the various forms of role strain that certain sociologists have referred to in their studies of organisations and professions.

Forms of role strain

Sociologists such as Kahn *et al.*[5] have referred to forms of role strain that I consider to be relevant to the role pressures that hospital ancillaries experience. Firstly, there is inter-role conflict. The theatre assistants who gave up their Saturday mornings to be trained often did so at the expense of their family commitments. Secondly, there is inter-sender role conflict. This can occur if a theatre assistant who responds to the request of the anaesthetist to set up the ventilating equipment for an operation might upset the theatre sister who wants the assistant to provide support for a surgical task. Kahn defined inter-sender role conflict as: "when

different prescriptions and proscriptions from a single member of the role set may be incompatible"[6] Thirdly, there is intra-sender role conflict. This type of strain is experienced when a theatre assistant is expected by a person in authority to carry out a task that is in breach of established rules or procedures. This type of behaviour is sometimes referred to as 'turning a blind eye', which can be stressful if a conscientious theatre assistant wants to please an anaesthetist or theatre nurse, but is aware that a mistake might invite a charge of negligence with all its legal implications.

These role strain situations are concerned with problems related to coping with people with varying and conflicting expectations that Kahn *et al.* considered to be important and which I consider to be relevant to the work role of theatre assistants and other hospital ancillaries. An example of this role conflict is exemplified by those who have an idealised image of the part they should play in the hospital, but who have to contend with the reality of their work experience which prevents them from fulfilling their aspirations.

Kahn *et al.* referred to other forms of role strain: personal value role conflict, role ambiguity, role overload.[7] A theatre assistant who objected to undertaking work that he regarded as being unworthy of his skills might experience personal value role conflict. If the theatre assistant took up a new appointment in a new hospital and was not sure what was expected of him, he would experience role ambiguity, sometimes described as role uncertainty.

If the assistant cannot cope with the work allocated to him in the time allowed, he will experience role overload.

Whilst sociologists have provided various definitions of role strain situations, it is difficult to draw clear distinctions between these situations. It is possible for a person to experience more than one form of role strain in one role relationship. The theatre assistants can experience inter-sender role conflict when they try to reconcile the expectations of medical and nursing groups. They might also experience intra-sender role conflict if the surgeon makes excessive demands upon them. Theatre assistants who are subjected to more than one form of role strain simultaneously will probably experience a high degree of role stress.

In this study, I endeavoured to identify those forms of role strain that ancillary workers described to me during the discussions I had with them. As a result of the many interviews I had with a cross-section of ancillaries and their supervisors, I found that the most common role strain experiences of ancillaries arose out of their relationships with nurses, patients and ancillary supervisors. These experiences tended to fall into the forms referred to in this chapter. They were inter-sender role conflict, intra-sender role conflict, role ambiguity and personal value role conflict. There was also another form of role strain that stemmed from the ancillarys' relationship with patients. This strain was experienced when ancillaries were expected by patients to provide emotional support and empathy. I described this type of role strain as patient involvement strain.

In this chapter I will describe the role strain experiences of ancillary workers. I will then set out to measure the degree of role strain experienced by the five occupational groups. In order to measure the role strain, I will focus upon the conflicts which ancillaries experience in their relationships with nurses and I will also focus upon strains that emerge out of their relationships with patients. I will describe the most common forms of role strain experienced by those occupational groups who were in close contact with nurses and patients. These were the ambulance workers, theatre assistants, porters and domestics.

Role Strain in Ancillary Work

Theatre assistants

Inter-sender conflict. I will now consider the main forms of inter-sender role conflict experienced by theatre assistants. Whilst theatre assistants work in situations where they come into contact with patients when they are in a semi-conscious or conscious states before and after an operation, they also have to attend to the perceived needs of the patients who have been anaesthetised and are unconscious. It is easy to appreciate that patients who are waiting to be anaesthetised or who have received a preliminary anaesthetic are worried and anxious. Sometimes the patients want to talk and will look for reassurance from someone in authority. They might welcome a reassuring word from the surgeon or anaesthetist, but they tend to direct their concern to the nurses or theatre assistants who are present in the anaesthetic room.

Whilst theatre assistants tend to be more involved with patients in the anaesthetic room, they are aware that theatre nurses are

directly responsible for the nursing aspects of patient care. Theatre nurses are very much aware that they are responsible for judging the condition of the patients and for relating to their needs. If the nurse is not present, then a theatre assistant will often assume responsibility for empathising with the patient. If the patient wants to talk to a theatre assistant, and the theatre assistant has been instructed by the theatre sister not to talk too much to the patient, and to be careful about the content of the conversation, then the theatre assistant can experience inter-sender role conflict and will have to decide how to behave towards the patient in this situation.

There is also a situation where a patient has received a local anaesthetic, for example the patient who has a cataract operation, who will have only the eye muscles anaesthetised. In this situation the patient can often talk quite freely but the theatre assistant must exercise considerable discretion when relating to to this person. In view of the fact that theatre assistants are conscious of the need to convince the nurses that they can behave in a professional manner, they might not always satisfy the expectations of individual patients who want to talk to them on medical matters.

We can also consider the problems relating to the conduct of theatre assistants when they are dealing with patients who are completely anaesthetised during an operation. Theatre assistants who work with theatre nurses who do not encourage them to be involved in 'scrub tasks', might be reluctant to engage in this support for the patient, although they believe they can help them more effectively by extending their theatre role into the surgical area. Whilst this

is an example of inter-sender role conflict, it can also be regarded as an example of role uncertainty, particularly if the theatre assistants have to work with a number of theatre nurses who have varying perceptions of the theatre assistants' role. It might also be considered as an example of personal value-role conflict, particularly if the theatre assistants resent being confined to tasks related to supporting the anaesthetist and aspire to be more involved in surgical tasks.

Theatre assistants can also experience inter-sender role conflict when they have to respond to conflicting expectations from theatre nurses and from their immediate supervisor, the senior theatre assistant. In this respect, a great deal depends upon the orientation of the senior theatre assistants. If they are interested in directing their theatre assistants into surgical support work, and this is not approved by the theatre sisters, the theatre assistants might find great difficulty in reconciling the expectations of these key people in his role set.

When we consider that theatre assistants are predominantly involved in work that supports the anaesthetists, but can also be expected to support the surgeons, we need to recognise the influence which these two medical groups have in shaping the role of theatre assistants. Anaesthetists and surgeons can have different expectations of theatre assistants and a great deal will depend upon the degree of support they give to assistants to extend their role, or indeed to the nurses who wish to confine the role of the assistants to anaesthetics. Theatre assistants, then, work in a role set that

includes various personal service professional groups and the role strain and stress that can be generated in operating departments may easily be appreciated.

Intra-sender conflict. I will now consider those conflicts that theatre assistants experience when they have to satisfy an influential person in their work group who makes inconsistent and incompatible demands upon them. This situation has been described as intra-sender role conflict.

The extent to which people experience role strain will depend upon the personalities of those who occupy specific roles in the work group. A great deal will also depend upon the type of understandings that have been established or negotiated in particular work situations. Let us consider one example of what might be regarded as a common form of intra-sender role conflict which was described to me by a senior theatre assistant. This senior theatre assistant referred to the close working relationship that he had established with a senior anaesthetist. The anaesthetist was aware of the fact that only SRNs were allowed to obtain drugs from the drug cupboard, yet he would frequently request his theatre assistant to collect a drug immediately before, or during, an operation. He would also, on occasions, expect the assistants to prepare the drug, in spite of the fact that such an act was in breach of established hospital procedures.

The older and more experienced theatre assistants would be prepared to oblige the anaesthetist but they were also aware that the more junior theatre assistants were reluctant to respond to these

requests. In order to overcome this difficulty, the senior theatre assistant would advise the anaesthetist not to put the inexperienced assistants in this situation and would offer to accept this responsibility in order to avoid an embarrassing situation.

When we also consider that theatre nurses frequently object to this practice, the theatre assistants' involvement in handling drugs can be even more stressful because they would also be experiencing inter-sender role conflict as well as intra-sender role conflict. Comments on this problem by other theatre assistants also illustrate this role dilemma:

> "In my job I am not expected to handle drugs at all. This is a nursing duty but I know that I can handle the situation and I help anaesthetists who want the drugs urgently. But if a similar order is occasionally given to an inexperienced assistant, I advise him not to obey and I will also tell the anaesthetist that this is an embarrassment for younger assistants".

> "Handling and preparing drugs is a nurse's job. You must be a State Registered Nurse to do so. It often happens that an anaesthetist wants a drug and he will ask me to help out, which I do".

Role uncertainty. Another cause of role ambiguity and role conflict which stems from the changing role of the theatre assistants exists when personal relationships cut across formal relationships. Although nurses in a hospital are opposed to theatre assistants

encroaching on their work, they will often interchange tasks with them because of pressure of work in the operating theatre. Indeed, there are occasions when theatre assistants will momentarily take over from an anaesthetist who may want, say, to go to the toilet in a hurry.

Some assistants are not formally qualified for some of the work in the theatre, neither are they being trained for it but, because of their experience over the years in the theatre and their personal relationship with the theatre sister, the surgeon and the anaesthetist, they are accepted as members of the team with a similar status to the nurses. They will be asked to do nurses' jobs and nurses will help out by doing an anaesthetist's work, or a theatre assistant's work:

> "I have worked here for over 20 years and have learnt from nurses, anaesthetists, surgeons and a senior colleague and I am often doing work which I am not supposed to, but at the same time the nurses will help out and do our work. We work as a team. Although officially I shouldn't do a trained nurse's job, neither should she do mine, but we do. If we didn't, the work would not be done and the patient would be affected".

A theatre assistant in another hospital said that one of the difficulties in his work was to adapt to the varying styles of the anaesthetists. The way in which an anaesthetist worked placed considerable pressure upon assistants.

"We have to adapt to the ways in which different anaesthetists and indeed their temperaments. We have to think ahead and anticipate what they want".

"I work on the Cardiac Unit where we are given every opportunity to express our interests and nurses accept us to scrub table, but one of our problems is working with different anaesthetists with their different methods".

"When you are working in the theatre under pressure, we have wo work together. Some people are irritable, quick-tempered and very demanding, others are not. Theatre assistants are there to help the anaesthetist, but we have to do other work, but they hang on to us without understanding the other requests".

Another aspect of role uncertainty in the operating theatre situation is the element of orientation of the theatre assistant. Some of the assistants find that they are more interested in surgical aspects of theatre work and this does not please the anaesthetist nor the theatre nurses. This is aggravated by the training recommended in the Lewin Report, where assistants can, after their basic training of 18 months, opt to specialise in anaesthetics or surgery. Some of the assistants have opted for surgery.

One of the most important sources of role conflict and uncertainty arises out of the role relationships of the theatre assistants and theatre nurses. There are some assistants who aspire to scrub table whilst others are not interested. At present most of the theatre nurses are opposed to theatre assistants moving into their traditional

area of work whilst others are more receptive to this new development. The following comments by theatre assistants illustrate the nature of this problem:

> "Not only have we got to please the anaesthetist, but we also have to keep in with the theatre nurses and some of them aren't happy about what we do which touches upon their work".

> "In this part of the hospital we are not supposed to scrub the table although we would like to do it, and many of us are being trained to do it. Our job is to assist but often we jump in and do work that we are not supposed to do"

> "I know what nurses are expected to do and I help out and do it. I measure swabs, count them and hang them. It's a nurse's job but I do it".

Whilst the patients are not always aware of these conflicts, they are at the centre of them because, although the groups are collectively concerned with the well-being of the patient, they can vary in respect of the way in which they want particular tasks carried out. In this type of situation the implicit, if silent but nevertheless urgent requirements of the patient, place certain expectations and obligations upon the theatre assistant.

The involvement which theatre assistants have with patients in their conscious state is most evident in the intensive care coronary unit. Here the theatre assistants assist the surgeon to instal pace-

makers in the patients' hearts, and they help to attach patients to the ventilating machine which assists them to breathe. In this situation they work closely with patients by talking to them and turning them every two hours. This type of work is appreciated by the nurses, as indicated by the following comments expressed by theatre assistants:

> "At first when we started here it was a woman's world and we had to step very cautiously, but now we are part of the team. Nurses accept us and invite us to help. In fact we are treated with more respect than the theatre boys*".

> "I remember when the assistants were taken into the coronary unit. They were not accepted by the nurses but after some argument, Miss Stewart the senior nurse, sorted it out by talking to them as a group and now they work well together".

Personal value conflicts. I have referred in this paper to the self concept of the theatre assistants. This concept is an important variable in any discussion on role strain. Strausse[8] stresses that when people are changing their occupational identity they are often concerned about their status. The comments expressed by the theatre assistants about their relationships with medical and nursing groups suggest that not only are they concerned about their occupational identity, they also illustrate personal value conflicts. Theatre assistants have a firm idea of the role they are expected to play, in the context of the Lewin Report, but they are not satisfied with the constraints they have to contend with in the operating departments.

* e.g. those theatre assistants not involved in coronary care work

"I am not satisfied with our status. We are technically under the control of the head porter. We are sometimes seen as porters because many of us started as theatre porters. We have to clock on like factory workers but we often put in extra work which is never recognised. If you look at our changing rooms and our conditions of work, you can see what they think of us. I don't think surgeons and anaesthetists are aware of this side of our lives".

"I remember when I worked in the theatre after I had completed a course of lectures in my own time on Saturday mornings. I was given a schedule of the operations to prepare for the day and I felt great. But later on I was told to clean the shoes of the theatre nurses and others and I felt lousy. So I decided to leave".

"We often work late in the evenings and have to send out for something to eat. We feel provision should be made to look after our interests. Sometimes we send out for a meal, but they will bring one for the surgeons and anaesthetist but not for us. We are worse off welfarewise in this hospital than others in Cardiff. Where else would you find a room like this for a restroom, all cramped and sweaty? We have no showers and it's highly infectious but there seems to be no money for these facilities. We also have to do chores such as cleaning the boots of the doctors and nurses. This is done at the Heath by the domestics. Why shouldn't it be done here? We also have to clean the walls of the theatre. This is not our work".

These comments suggest that not only are theatre assistants uncertain about what is expected of them by anaesthetists, surgeons and nurses, but they also experience inter-sender role conflict in their relationships with these groups. The theatre assistants have to cope with the incompatible expectations of the professionals that they work with. If a surgeon would like a theatre assistant to assist in scrub activities and the theatre nurses want the assistants to confine their work to supporting the anaesthetist, then they have to satisfy one expectation at the expense of another. If the anaesthetist does not want the theatre assistants to support the surgeon, then they have to take this consideration into account. The problem of role adjustment is further complicated if any of the assistants have a personal preference for working in the surgical or anaesthetic area.

The pressure upon the theatre assistants to adjust to their work role is aggravated by their personal values. Most of them see themselves as para-medical workers and seek acceptance in a work group dominated by professionals who, in the main, are people who enjoy a higher degree of occupational status than theatre assistants. When we consider that theatre assistants have to impress medical and nursing groups in order to earn their respect and recognition as one of the pre-conditions for para-medical professional status, we can appreciate the many difficulties that they have to face in their work.

In view of the high degree of role uncertainty and conflicts experienced by theatre assistants they can be regarded as people in

a *marginal role*. A marginal role is one that has not been institutionalised. The role is marginal because the people who occupy the role experience an inadequate fulfilment of the expectations that they brought to their work and which have been generated in it. The roles of the doctor and the nurses have been well established and institutionalised and they can use their personal resources fully in their work. This, unfortunately, cannot be claimed for the theatre assistants.

Ambulance workers

Most of the ambulance workers work in situations that can induce role strain. The main causes of role strain arise out of their relationships with patients, doctors, nurses and ambulance officers. These people can be described as the main role senders in the role set of ambulance workers.

Ambulance workers have two main areas of work. The first area is concerned with routine duties relating to conveying patients to hospitals, clinics, schools and other therapeutic institutions. The second area of work is concerned with emergency care. Within both of these areas, there are particular role strain problems that have to be coped with.

Inter-sender conflict. If we examine the typical situations that give rise to inter-sender conflict conveying patients we find that many problems arise out of the varying expectations of people in the role set. There is the situation where the ambulance worker and his or her colleague have to work to a very tight time schedule which has been worked out by their controller, who will determine the times

when individual patients should be collected in order that they can be conveyed to hospital or other place of care.

Most patients are scheduled to be picked up before 10 a.m. so that they can be registered at the receptionist's desk at the hospital but, in practice, it is often the case that some patients are collected after 10 a.m. This is usually due to the particular problems of individual patients. For instance, an elderly patient might have difficulty getting ready in the morning. These situations can often generate feelings of anxiety among the patients, particularly if they are attending the hospital for the first time. They might express their concern to the ambulance workers and very often, the ambulance workers are aware of this concern but do not have the time to reassure the patients that their treatment will not be adversely affected. Each patient can be a problem to ambulance workers. Geriatric patients often have to be dressed or partially dressed and helped to the ambulance and this can take up to 12 or 15 minutes of their time. Some of the geriatric patients need a lot of attention when they are collected and when they are returned to their homes. The views of ambulance workers quoted below describe the nature of these problems:

> "Many of the old patients have no one at home when we call for them, and we often have to help them to dress, talk to them and cheer them up. When we take them home we know they want a cup of tea and, if we can manage it, we will make a cup of tea for them, although it's not our job".

> "Some of the homes where we collect patients are not very accessible. A flat at the top of a four-storey building means

that we have a hell of a job to carry a patient downstairs and heaven help us if there's a spiral staircase there. Just imagine the physical and mental strain that this places upon us ambulance workers. We have to press on because there are other patients to be dealt with and the controller has other work for us to do".

"It is not just a question of collecting patients. There is the added responsibility of driving them to the hospital. If you have an elderly gent with a weak heart you try not to go too fast, and you have to have your wits about you to cope with the traffic. A sudden swerve can upset a patient".

Ambulance workers also experience inter-sender role conflict when they take a patient to the hospital for what they consider to be emergency treatment, but find that nurses are busy and do not provide immediate attention. Ambulance workers usually appreciate the pressures imposed upon nurses but they can feel frustrated if they have to wait a long time for their patient to be dealt with. Although ambulance workers expressed this frustration, they did not place any blame upon the individual nurses, although they believed that some nurses were less considerate than others. The ambulance workers were very much aware that nurses were often overworked and under pressure and could not give immediate attention. We might also justifiably argue that the nurses in this situation experienced role pressures from the conflicting demands of the patients they had to deal with, as well as the concern of the ambulance workers.

Another type of inter-sender role conflict expressed by many

ambulance workers was due to the conficting expectations of their supervisor/controller and nursing staff. Ambulance workers expressed the view that nurses often expected them to remain with the patients until they were dealt with, but they themselves were also conscious of the demands on them by their controllers, who are concerned with dealing with a heavy work load.

Ambulance workers also mentioned the obligation they had to particular patients, such as a diabetic patient, or an elderly patient, when they were engaged on non-emergency duties. If they were called upon by control from their outpatient work to deal with an emergency case, they were very much aware of the problems of these patients, who were left behind and inconvenienced.

Ambulance workers are often called upon to do work that is not considered to be in their domain and a story told by a district nurse illustrates the reason for such high regard:

> "I was a new district nurse in a middle class residential area and I noticed that two psychiatric cases were on my list. I called at the house and found that one patient was an elderly man, the other, his sister, an elderly lady. The man seemed to be leading a normal life but when I found his sister I was horrified - she was in a dreadful state, surrounded by excretia, remnants of food and drink. I contacted the ambulance service and they came immediately to help me in this stressful situation, to clean the patients and take them to hospital".

Intra-sender conflict. Let us consider the intra-sender conflict. Many ambulance drivers were dissatisfied about their position under the Road Traffic Act, 1968. It is generally recognised that the public should give priority on the roads to ambulances, but there are areas of uncertainty which cause anxiety. Of particular concern is the legal position of the ambulance worker who takes a decision to drive through the traffic lights when the red for danger light is on. The present legal situation is that ambulance workers should not cross the traffic lights if the warning red light is on, but some ambulance workers expressed the view that they should have the right to exercise their judgment on this matter when a patient's life is at stake. This problem is illustrated by a news item in *The South Wales Echo* on September 8th, 1975.

> South Glamorgan ambulancemen believe new rules forbidding them to drive through red traffic lights while on emergency calls may have cost a patient's life. The incident happened just after the crews' union leader Mr. Peter Meredith had warned 'Time is running out for some unlucky person. It is scandalous that someone has got to die before we prove our point'.
>
> The patient was an elderly man who appeared to have suffered a heart attack, according to the ambulanceman called on the emergency and the doctor who examined him. The ambulance attendant was Mr. John Jones of Union Street, Graig, Pontypridd. He was called from St. David's Hospital, Cardiff, to Stanwell Road, Penarth. In a written statement to his union, the National Union of Public Employees, he says his vehicle was delayed at traffic lights controlling the Clare Road - Tudor Road junction for one minute 15 seconds. Continuing along Penarth Road, lights delayed the journey for a minute at Clive Street junction and another minute at Sloper Road junction.
>
> He said the patient's heart had stopped and although cardiac massage was applied the patient could not be revived. 'In my opinion this life may have been saved but for the delay', said Mr. Jones. The patient collapsed in Stanwell Road, Penarth, and was attended by a doctor from the nearby centre. The doctor, who declined to be named, said that only a post mortem examination could reveal the actual cause of death.

> Mr. Jones has served a total of four years with the ambulance service as a driver-attendant and holds the service proficiency certificate. He said a large part of the training concerned resuscitation methods following heart failure. He gave the patient oxygen and took the action indicated for dealing with heart failure cases while the ambulance drove to Sully Hospital.
>
> Mr. Meredith, secretary of the Cardiff branch of NUPE, said: 'This is the sort of tragic situation which we have predicted. It is something we have feared all the time. Let us hope that now someone will take notice, but it is not going to help this poor chap or his family'.
>
> A spokesman for South Glamorgan Health Authority said: 'Until a great many more details are known about the circumstances it is obviously impossible to say whether any delay would have affected the medical course in this particular instance.

Ambulance workers realise that they are forced into situations where they have to make life and death decisions, yet they do not have the professional authority of the doctor. They realise that if they hesitate to take a decision, delay can be fatal for a patient. Or again, if they make a mistake in lifting a patient, they can cause permanent injury. They also realise that, very often, a decision that is taken might result in a loss of life. A story told to me by an ambulance worker with over 20 years experience illustrates the type of stress ambulance workers have to cope with, which can be described as intra-role conflict.

> "I was called out on an emergency case one day. A workman digging a trench found that the banks on each side of him had collapsed. I knew that unless I acted quickly, he would suffocate. I decided to use a bulldozer to excavate him because to dig him out manually would be fatal. The tragedy was that he was injured during the excavation and he died. No wonder ambulance workers feel they should retire at 55!"

Role uncertainty. Ambulance workers can also experience role uncertainty when they are engaged on emergency work. When they are called out to deal with an emergency case, they will often be worried about the type of case they will have to deal with when they arrive at the scene of an accident or illness. Whilst they have some information about the nature of the case from their control officers located at headquarters, they will not be satisfied until they personally arrive at the scene to assess the gravity of the situation. Typical comments on this uncertainty are presented below

> "I have been in this game for 20 years but when I am sent out to an emergency I keep wondering how serious the accident is or how quick I will be locating it. I feel that my mouth goes dry and my stomach wobbles a little until I get there".

> "When I am called out on an emergency job I get all tensed up. You never know what you are going to meet".

When an ambulance worker arrives at the scene he will often find that he will be under considerable pressure when dealing with the patient. If he is involved in an emergency case he will be the person who will take charge on the spot. He will decide how to lift a patient or what drugs to give him, or any other form of emergency treatment. He will be working in close co-operation with his fellow ambulance worker. Very often these men have built up a good working relationship and are able to come to a mutual understanding about what procedures to adopt with the patient.

If we look at the role uncertainty experienced in this situation, we find that the ambulance worker is torn between doing what is best

for the patient on the spot and taking him as quickly as possible to the hospital that can cater for this type of illness or accident. If it is a particular type of accident case, only certain hospitals are able to take them or, in the case of coronary illness, only certain hospitals can provide the intensive care needed for the patient.

There are occasions when the ambulance worker will exercise his judgement and he will decide which hospital the person should go to after taking into account the condition of the patient or the accessibility of the hospital. As one ambulance man put it, "I remember on one occasion I took a person to a hospital which I considered to be the most suitable one, but the patient died. When the Coroner asked me why I passed a particular hospital, I replied that this hospital did not have a casualty unit. As a result of this experience I decided to be careful in the future".

Another role strain which ambulance workers experience is concerned with the most suitable route to travel in order to take the patient to hospital during an emergency call. The controller is responsible for outlining the route which will take the patient to hospital as quickly as possible. Some of the ambulance workers with whom I discussed this problem expressed the view that they were usually the best judges of this situation. Other ambulance workers were willing to accept the authority of the controller. Typical views expressing this dilemma are quoted below:

"I remember once I picked up a boy who had a serious accident and was badly injured and I knew that minutes were vital. I

suggested to control that I should take a particular route but I was strongly advised to take another. I had to accept this advice but I felt that I should have the authority to make the final decision for the quickest route".

"If there is any doubt about the quickest route for taking a patient and control advise us, then we take the recommended route".

"Very often control are not familiar with all of the various routes to pick up a patient and the men on the road have a good local knowledge of some areas and also up to date knowledge on road work that is being carried out. We should be the person who should decide how to reach a patient but it's a heavy responsibility to ignore control. Yet we feel that our knowledge is more up to date than control".

Another source of role stress for ambulance workers is the lack of co-operation that they have from the public when they are dealing with emergency cases. In South Glamorgan it is clearly laid down by the Chief Ambulance Office that emergency accidents in the west of the area are taken to St. David's Hospital, whilst accidents occurring in the east are taken to the Royal Infirmary hospital. But on particular days, when traffic is heavy on the road and when people are busy shopping in the location of St. David's, ambulance drivers are sometimes delayed for periods of up to 15 minutes because of traffic congestion.

"I have often found that when taking an emergency accident case to St. David's that I am delayed because of traffic congestion

and awkward parking of lorries delivering goods to the shops. We have a 'hell' of a job to get through and you would be surprised how awkward some people can be. It's difficult to get out to the road to talk and explain to everybody that a delay in taking a patient to hospital can be serious. Even when the blue lights are flashing, we can be held up".

Personal value conflict. A number of ambulance workers that I interviewed complained that they did not have enough support and consideration from doctors. There were occasions when doctors were not available to help with serious cases. Ideally, they should be supported by doctors on serious cases but, unfortunately, this support was not always available. They also complained that doctors made arrangements for patients to be picked up by the ambulance although in their view, public transport would have been most appropriate.

The concern which ambulance workers expressed about the misuse of their skills can be described as a personal value type conflict. Many ambulance workers were not happy about some of the menial tasks they had to fulfil, such as cleaning the exterior of their vehicles. This type of task did not conform to their occupational image of paramedical type professional workers.

Complaints were also expressed about their transporting of sub-normal children from their homes to their schools. This work, which was primarily concerned with transporting children could, they felt, be done by trained drivers in the Education Department. Concern was also expressed about being called out to pick up drug addicts and alcoholics. This, they maintained, was a waste of their time and could be better dealt with by the police.

Ambulance workers are often proud of their knowledge and skills and they can be offended if the opinions that they present to nurses about the condition of the patient do not appear to be appreciated. They also resent the fact that they are prevented from treating patients by administering drugs because this is considered to be a doctor's responsibility. Their pride in their work is expressed in a comment which is typical of the views of many ambulance workers:

> "The reason I stay in this job is because I feel a strong sense of satisfaction from helping people .... I can honestly say that I can do some jobs that some doctors cannot do. Some of us can insert a trachea tube into a patient and not all doctors can do this. This is the point about our work. You save a man's life because of your skill. What can be more satisfying than this? I am pround to be an ambulance man".

Porters

Hospital porters have a wide range of role senders that they have to relate to in their work. They experience inter-sender role conflict, intra-sender conflict, role uncertainty and personal value conflict.

Inter-sender conflict. Most of the porters in this survey found themselves in situations where occasionally they have to contend with conflicting expectations from nurses and patients. The discussions that I had with porters and nurses enabled me to appreciate the inter-sender conflict that they experienced. These discussions and

observations revealed that many porters who were newly appointed had some difficulty in adjusting to their new environment. I found that there were many occasions when the attitudes of the porters were in conflict with the norms of the hospital sub-culture. Many new porters found that they had to learn from experience the problems that they would encounter when working in the wards, where they came into contact with patients and nursing staff.

The normative expectations of nurses towards the behaviour of porters in the ward are illustrated by the following norms: porters are expected to wait for permission before they enter a ward. They are not expected to go near the patients' beds. They must be circumspect in the way in which they deal with and talk to patients. They are expected to be punctual when collecting patients for therapeutic treatment or for the operating theatre. Whilst these norms form the basis of porter/patient/nursing relationships, a great deal will depend upon the personalities and the attitudes of porters and nursing staff and, in particular, the nursing sister in charge of the ward and the way in which they interpret and adhere to these norms. If a porter is particularly boisterous and a nursing sister authoritarian, then certain problems will probably arise which can undermine morale in the ward and strain relationships between portering staff and nursing staff. Role conflict will occur even with the more experienced porters, particulary if they have strong opinions about what they can do for the patients and the patients expect them to help.

Examples of the most typical role conflict situations between patients and nursing staff are illustrated by comments expressed by

porters, quoted below:

"Some sisters are harder to please than others. They will expect us to be punctual, not too late, nor too early, when calling for a patient. They don't realise what other work we have to deal with".

"When I am working in the radiography department I am in constant demand by others, such as patients, nurses and doctors".

"I have often been told off for going too near the patients' beds, although I know the patient wants to talk to me".

"I know that some sisters think I am too familiar with the patients but I think I am just being friendly. I can't help it. I just like making people feel at ease".

"Very often a patient will want to talk to me about his troubles and I try to cheer him up, but I have to be careful what I say, particularly if he asks questions about his condition which I can't answer".

The porters involved in situations of this type are forced to cope with the conflicting expectations of patients and nurses. Whilst the nurses are usually obligated to the porters for their help and support, there are the occasions when nurses are concerned that porters do not get too involved with patients and do not upset them. They also require them to meet their requirements as efficiently as possible.

Patients may not be aware of the porter's technical duties, but will very often seek the emotional support from a friendly porter who will often respond by being cheerful and helpful.

If we now consider the conflict that the porters experience because of the requirements of the head porter and the nursing staff, we can understand some of the main determinants and causes of this type of role conflict. The head porter is responsible for the work of the porters but a great deal depends upon the individual porter's sense of responsibility and discretion about the way in which he relates to patients, nursing and medical staff. There are occasions when a porter is working in the hospital ward or in one of the medical units, such as the renal unit, with the sister and other nursing staff. The porter is often expected to conform to their requirements whilst the head porter has to consider the needs of the hospital as a whole. These different sets of role requirements can give rise to a conflict of expectations for the porter.

There are occasions when there will be a staff shortage in the hospital due to holidays, absenteeism or a high rate of labour turnover. If this shortage applies to portering staff and some of the wards that they service, porters will be torn between the requirements of both sets of role senders. Porters in this survey were particularly worried about the problem of meeting the head porter's needs to keep the hospital clean, to collect refuse and dispose of it and the pressure to help out on the hospital ward. The strain on the porters is how to reconcile both requirements and

yet be free from transmitting a cross-infection when adjusting from one role task to another. Comments made by porters reflecting this concern are quoted below:

> "Labouring jobs, such as collecting rubbish, should be done by labourers because we have to deal with patients both in and out of the ward, and how can be keep clean throughout the day?".

> "Sometimes, if there's a lot of work in the ward we are very busy helping out there, but I know that the head porter has a lot of work elsewhere in the hospital for me to do".

Intra-sender conflict. Hospital porters are not trained for nursing tasks, neither are they formally expected to undertake nursing tasks. According to their job descriptions they are not expected to provide a therapeutic service for the patients. It is, however, customary practice in most hospitals for porters to contribute to the individual needs of the patients that they meet. Porters who are in close contact with patients, find that there are occasions when they play an important part in the ward when they help nurses to lift patients or help in turning them over in their beds. The porters are not only called upon to help because of their physical strength, they are also expected to handle the patients correctly and gently. Technically, this particular set of tasks can be regarded as a nursing task and when the nurse is capable of fulfilling it, she will do so. But there is no doubt that nurses need the aid of porters, particularly if there are no male nurses available. When porters help patients through these tasks, they find that the manner

in which they lift and move patients may not comply with the manner in which most nurses perform this task. It can be appreciated that both the nurse and the porter are concerned about the patient, but there is an area of disagreement between both groups as to how these tasks should be done. Comments made by porters illustrate the different methods adopted:

> "I often find that sisters will not like the way we lift patients. We believe we have particular techniques which are better than those recommended by nurses".

> "We help nurses to lift heavy patients. We haven't been correctly taught but we know by experience the most suitable methods to use, although nurses often don't approve of how we do it".

> "Porters are also expected to deal with troublesome situations in the ward, such as a difficult patient who might be confused 'coming around' after an operation. These patients can upset other patients and the nurses. Many nurses find that they cannot cope with this situation and they send for the porters to assist them. This particular task is traditionally regarded as the nurse's responsibility and in the mental hospital male nurses are responsible for this work, but in other hospitals porters are called upon to help".

> "I have been called to the ward quite often to deal with awkward patients. I have been hit once and other porters I know have been bitten. It's not my job. In fact it's a nursing job, but we always help in this way, if we are needed".

"I have often been called up to the men's ward if there's a row there. It's not a pleasant experience but I do it to help the nurses and the patients in the ward, although I don't think it's my job".

"Sometimes I am asked to do jobs which I am sure I shouldn't do. I had to clean a dead body the other day. The body was brought to me in a terrible condition. I was asked to clean it, which I did. But I was told by other porters that this was a nursing job, but I didn't mind doing it".

The above situations which have been described by the porters can be described as role uncertainty situations. The porters are not entirely certain about their obligations when called to deal with these problems. They realise that they have not been trained to lift patients or control them and they lack the assurance that it is their sphere of responsibility. They feel, however, that it is their implied duty to deal with such problems and help when required.

Most of the role strain situations that I have described arise out of the porters' involvement with the patient. It is quite evident from the comments made by porters and from existing documentary evidence (Evans and Morgan[9]; Smith[10]) that porters are not trained to help in some of the fringe nursing activities that they become involved in through their work. It is also evident that whilst most nurses appreciate the support of portering staff, they are concerned about their becoming too involved with patients. It is also clear that porters, like domestics, experience role ambiguity through

involvement in nursing tasks, and role conflict when there is a shortage of staff. The evidence also indicates that many porters felt that they could do much more for the patients than they were allowed to do, and points to the need for a broader training to be provided for porters. The need for such training has been recognised by the King Edward's Hospital Fund's recommendations, 1965, and the evidence in this current investigation indicates that these have not been implemented, but the need is probably greater now because of the crises in the hospital service and the importance of making the best use of the labour force.

Another type of role uncertainty is experienced by many hospital porters and is illustrated by two specific examples. One type is concerned with the porters' involvement in handling and installing mobile equipment and aides, such as medical gas cylinders. The other form of role strain is concerned with the porters' vulnerability to cross infection.

Nurses are technically responsible for erecting and operating such mobile medical equipment as medical gas cylinders and incubators. The porters, however, transport the equipment to the ward or the required unit. Very often the porter will relieve the nurse of the responsibility for installing the equipment, but whilst they are willing to instal the equipment because they feel they are helping nurses and patient, they are conscious that this is not an assigned responsibility. They are, however, concerned if an incubator fails to work and would feel responsible for it.

Porters, like most employees in the hospital are conscious of

their responsibility to avoid cross infection and of the dangers to patients and staff. Yet many porters were very concerned that there were times when they worked in situations where they were exposed to cross infection. One porter described this situation:

> "There are times when I am involved in doing three or four different jobs in an hour - one minute I am collecting and burning rubbish, or working in the sluice room. The next I am wheeling a patient to and from the ward, and then I can be wheeling a food trolley. In theory I should clean myself thoroughly after each job, but in practice I find that I haven't got time for this or the facilities are not available to us. In situations like this I can carry germs; and this can be worrying".

I have not pursued this matter in any depth but comments like this indicate some concern and should be noted.

I am not arguing that this is a common problem in hospitals, but the fact that many porters and head porters expressed concern about cross infection clearly indicates that it is a source of intra-role strain. If they adhere meticulously to the high standards of hospital cleanliness they are aware that much of their daily work will not be completed. Yet by responding to the pressures of the day they can transmit cross infection.

We can appreciate the pressure that porters have to contend with in their work. One of the main reasons for such pressure may be attributed to the lack of adequate training which porters receive in their work to help them to cope effectively with their tasks. Another

reason is that porters become involved with the patient care aspect of their role which they find more rewarding than some of the other technical tasks.

The various studies that have been made of the hospital porters illustrate the lack of training they receive (Evans and Morgan[11]; Smith[12]). There is some evidence, too, of a high wastage of new porters which suggests that if people are not trained for their work but have to learn through experience, as shown in this study and in other studies, the new recruits have difficulty in adjusting to the new hospital environment.

Role uncertainty. Concern about their work in such tasks as refuse disposal and collection directs our attention to the conflicts which porters experience between the requirements of the head porter and the administration, and the porters' perception of their role. This perception, which many porters conveyed to me, illustrated the value which they attached to the patient care aspect of their role. Many of them outlined what work they would like to do and what they had to do. Some porters argued that they should be trained to help the patient far more than they do. They would like a basic understanding of medical and nursing tasks. They would like to spend less time on menial tasks and more time on patient care. Some typical comments on this conflict were,

> "We whould not be employed on driving jobs when more can be done for the patients. We should not be used to work the incinerators when we could do more for the patients".

"I would like to spend more time with the patients. For instance I would like to be more involved with the physiotherapy unit where I could do more for the patients instead of some of the work that I am doing".

"I feel that my lack of knowledge about the medical terms used to handicap me in my work. When I worked on the casualty unit, I found that when an emergency occurred, it's all hands on deck and I feel that I could help much more. The casualty sister once asked me to fetch an oral pad, I had no idea what she wanted. We should be given a better training to help patients if needed".

Domestics

Inter-sender conflict. If we consider some of the role conflicts that domestics encounter in their work, we find that the most common conflict concerns the meeting of different expectations of their role set. The 'significant others' in the domestics' role set (when they worked in the ward) would be the ward sister, the companion domestic, the domestic supervisor and the patients. Whilst the problems would vary in each situation there was a common pattern which is illustrated by a few examples which I will describe.

A domestic was pressed to clean the ward in a set period of time. This would entail a number of tasks. During the completion of these tasks there would be various role pressures that she would have to cope with. A ward sister would expect the domestic to fit in neatly with the nursing routine which she would be concerned with

such as washing and cleaning the patients, preparing the patients for the doctor's round or preparing the patients for visitors. The domestic would have to plan her programme and perform her tasks to the satisfaction of the domestic supervisor, who might also have some additional tasks outside the ward for the domestic to complete. Apart from these role expectations there were also the patients who would involve the domestic in conversation or in requests to them for minor favours. They way in which the individual domestic would cope with these pressures would depend upon her personality and work orientation. Some of the domestics would devote more time to the patients than others, who would be so concerned with their work schedule that they would not allow themselves to be distracted by requests for help from patients. Situations of this type gave rise to intra-role and intra-sender role conflicts. A typical situation is described below:

> "I have so much to do in the ward, not only with cleaning it but in helping out the patients there when I can. I know that helping patients is not my job but, if I think they need help, I will do what I can. But if they are shorthanded in another part of the hospital, I have to be brief with patients to finish my work so that I can help out elsewhere".

Inter-sender role conflict situations exist when the domestic is confronted with incompatible demands and expectations with the various role senders in her role set. If the patient, the domestic supervisor, the companion domestic or nursing staff placed differential demands on the focal domestic, she would be compelled to cope with

these expectations. A sister would want the ward cleaned before the doctors or visitors arrived. A patient would involve a domestic in conversation or request some favours. The companion domestic might request her help with a difficult task and the domestic supervisor would be anxious for the domestics to complete their work in the ward and to help out elsewhere. It could be argued that some of these expectations are not legitimate, as in the case of the patient who might not be aware that domestics should not help patients or be too involved with them. If, in practice, domestics help patients and are seen to be encouraged to help by nursing staff, then an element of legitimacy is brought into the situation. Although on this particular occasion there is pressure from the sister to clean the ward, the patient can assume that the domestic might help her on this occasion, as she might have helped when their was a shortage of nursing staff. If there was both a shortage of nursing staff and a shortage of domestic staff, the expectations of both groups of role senders would intensify the conflict of the focal domestic. Comments by domestics illustrate the specific nature of their inter-sender role conflict:

> "Very often I haven't got time to help a patient because I have too much to do, although there are occasions when I can".

> "I will always try to help a patient but I know there's a limit to what I can do as far as helping the patient goes. It all depends upon the ward sister. Some of them like us to help out, others are stricter and don't want us to get too involved with the patient".

"If I help a patient and give him a glass of water, I dare not hold it for him because that's a nursing job, although a patient would ask me to help".

"If nurses are busy I will fetch a bed pan for a patient, but it's not really my job".

Intra-sender conflict. Domestics also objected to unreasonable demands make upon them and felt that such demands showed a lack of consideration for them. They objected to having to repeat work which they had completed once.

"A sister asked me to clean the corridor of her unit, which I had already done. What the sister didn't realise was that I had already cleaned this corridor, but that workmen came along to do a repair job there and made a mess in the corridor. In the end I cleaned the corridor again after I explained to the sister what had happened because I knew that we were concerned with the patients. I realised that in order to re-do this work I had to neglect other jobs and this wouldn't please the supervisor and other nurses".

Another form of role strain that I found amongst domestics was the conflict between what they considered to be a reasonable task according to their standards and their structured work schedule, and what they were actually expected to do. Some of the domestics who were responsible for cleaning the apartments of the doctors found that there were a few apartments which were so untidy that they objected to working there. It could well be argued that there were implications of status

behind such action, a feeling 'that domestics could cope with such a mess'. One can recall the dispute that took place in Singleton Hospital, Swansea, in 1974 when a domestic refused to clean the doctors' rest room after a farewell party and the domestics, as a result of being instructed to do this work by the administrator, withdrew their labour and a strike occurred. A comment made by a domestic illustrates this concern:

> "I object to cleaning up the mess in some of the doctors' apartments. Most of the apartments are in a reasonable condition, but some are not, and I don't see why we should clean up the mess".

Personal value conflict. Another minor source of role conflict in the role set exists between the domestics who work together in the hospital. It is the normal practice in the hospital for domestics to work in teams of two and a great deal depends upon the degree of co-operation that they establish in their working relationships. There are occasions when two domestics do not work well together and one of them will appeal to the supervisor for another partner, or she will decide to take the lion's share of the work and carry on, or decide to work alone. This was described by one domestic supervisor in the following terms:

> "There are the times when a girl will say that she can't get on with another girl. They say she is not pulling her weight and I have to sort this out. There are a very few who are not good workers and some of the girls would prefer to work on their own. It's difficult for me to deal with this because

others will object if I place them with another partner. We can't sack them so I try to get them to work together".

In recent years, concern about the effective use of manpower has concentrated upon determining the appropriate number of ancillaries for a particular hospital. But when absenteeism and labour turnover are taken into account, the burden of work has to be carried by the remainder of the workforce. This point was clearly established by Jefferies[13], who said, "Many conscientious staff were overworked. These people as a result of this, sometimes suffered a long and serious illness themselves, yet the authorities has stated they are overstaffed".

The domestic in the hospital service is generally viewed as a low-grade, low status worker. Many people do not appreciate the importance of their work in the hospital service. Their work is important because they are primarily responsible for maintaining a clean physical environment for the hospital patient and hospital worker. The constant battle with germs and bacteria in the hospital, and the struggle to prevent cross infection, is undertaken every day by domestics. Without this work, the patients' health would be undermined.

To appreciate the technology that supports the domestics in their tasks, we need to look at some of the materials and equipment that they use (see Appendix D). The operation of such equipment and material demands considerable physical effort from the domestic.

When we consider that the domestics are women who undertake

hard and demanding work in hospitals, housed in old buildings with a labyrinth of wards, hostels, offices, workshops and so on, we can appreciate the demands made upon this group of workers. Many of the hospital units are separated from each other by long winding staircases which tax the physical strength of older women. Occasionally, units are separated by an open yard which means that, in the winter, women who have been working in a centrally heated ward may have to walk in the cold and wet yard to have access to another hospital unit where they are needed.

It is also relevant to this discussion on the role of the domestic to consider the historical background of this particular occupational group. According to a note by Mrs. J. Mortimer*[14], the first domestics were employed as servants of the hospital matron. When domestics became employed in work in hospital wards under the supervision of the Sisters, many of them came from the local orphanages, often starting work at the age of 12 and 13 years. The girls often started work at 4.30 a.m. and did not finish until the last meal had been provided in the evening. This was the situation which prevailed in the latter part of the 19th Century and it is reasonable to infer that the origins of their low status have not been entirely erased from the folk memories of this occupational group. When the Salmon report was implemented in 1966 the domestic worker was no longer under the supervision of the ward sister. Prior to this change, nurses as well as domestics, would work together on many of the manual and often dirty chores (although the domestics

* This comment was passed to me by a domestic supervisor on a supervisory course, with no academic reference

were expected to be primarily responsible for these manual tasks).

In some respects, the relationship between nurses and domestics resembled the relationships that exist today between theatre assistants and theatre nurses and, indeed, theatre porters when there is a shortage of staff. It has been a tradition that SRNs and SENs in the operating departments will help out on the most menial tasks to ensure the welfare of the patient. This was pointed out to me by theatre assistants and theatre nurses when I talked to them.

Some nursing sisters and some domestics have expressed the view that when the Salmon Recommendations were implemented, the nursing sister lost control of the domestics. The domestics were also concerned about the change because they did not see themselves as part of the ward team. However, a senior domestic supervisor expressed this view about the part that domestics can play within the Salmon structure:

> "Today the domestic assistant is a valued member of the ward team; not only does she release the nurse from non-nursing duties but she is an outside contact for the patients, someone they can talk to while their lockers and beds are being cleaned, to post a letter, do small errands of shopping for things they forgot to get or were unable to buy from the WRVS trolley. Gone are the days when a hospital cleaner was looked upon as a Mrs. Mopp figure with down-and-out heel shoes, red hands and soiled worn knees. Now they come smartly dressed, can talk intelligently about many things and know that hospital

cleaning is a responsible job, although very different from cleaning at home. They take a pride in "their ward" and in "their nurses" and woe betide you if you, as a supervisor, upset any one of them".

The comments are also relevant to this study of personal service orientation, because they illustrate the nature of the dissatisfactions that ancillaries are aware of. Ancillaries in the four occupational groups who were in close contact with patients, stress the importance of their contribution to patient care, but they also indicate that they become involved in fringe nursing areas which extend beyond their prescribed role. In these comments they imply that they are not trained for the fringe nursing activities, neither do they derive official recognition for this contribution.

The comments also bring out the resentment of many of the ancillaries about their status in hospital organisation. The theatre assistants who expressed the view about their inferior welfare amenities relative to those for the medical groups illustrate this concern. The domestics who resented cleaning the residential accommodation for the doctors, suggest that the way in which doctors neglect the cleanliness of their rooms and expect the domestics to tidy them up, is another illustration of their perception that they are regarded by medicals as being in low status occupations.

The views expressed by the porters, that they have to contend with conflicting expectations from patients, nurses and supervisors, indicates the way in which they become involved in enlarging their role, in order to respond to the day-to-day problems that emerge in

hospitals.

I have considered the role strain which ancillaries experienced in fulfilling their tasks and in their relationship with nurses. I will now consider the role strain they experienced through their relationship with patients.

Role strain and patient relationships

Emotional needs of patients

In order to get at the root of the relationships which ancillary workers establish with patients, we must consider what the patient wants from the hospital. Sociologists who have studied the role of the hospital patient (Anderson[15]; Coser[16]) found that patients needed emotional support. Patients will look to professional groups for emotional support as well as for medical treatment for their illnesses. Patients will often place great stress on the personality attributes of physicians and nurses (Johnson and Martin[17]; Anderson[18]; Evans[19] and Robinson[20]). These sociologists outlined how a patient who assumes the sick role is entitled to assume that he is exempt from certain normal social responsibilities. He cannot be expected to take care of himself and he should want to get well. He should seek medical advice and be prepared to co-operate with the medical profession. He should be free from the burdens of domestic care.

It is recognised that the transition to the sick role will involve the patient in trying to cope with an adjustment to the

hospital environment and the new role relationships he will enter into. Patients relate to doctors and the nurses and will expect medical care from them, but they will also want to be treated as individuals. Evans[21] argued that some patients placed more emphasis upon the hospital as a place to satisfy primary needs, such as attention, rest, friendship and kindness. Others were more orientated towards the hospital in instrumental terms, by regarding the hospital as the most appropriate place to be treated for a disease or ailment.

Robinson[22], commenting about the role of the physician in relation to the needs of the patient, recognised that patients wanted information about their illness; they wanted to know how long they would have to stay in hospital. The patient could be bored, worried and lonely. He also recognised that patients could be upset by the attitudes of doctors, nurses and medical students and that many patients wanted someone to talk to and to confide in. Hayward[23] established that over half of the patients were afraid or upset at having to go into hospital. Anderson[24] found that over 66% of the patients studied in her investigation experienced emtoional discomfort. Some of the main causes of discomfort were boredom, communication problems, domestic worries, staff who were discourteous, other patients and visitors who overtaxed their energies. Other patients were lonely and confused. Anderson also established that patients wanted to talk about their personal worries. Nurses also recognised these needs of the patients.

Roth[25], in his investigation of the attitude of tuberculosis

patients in hospital, found that patients were always anxious to talk and one of their main concerns for some form of reassurance.

Roth found that nursing aides were able to establish a more friendly and trusting relationship with the patients than were the doctors or professional nurses[26]. The reason advanced for such a relationship was that the aides were more closely involved in doing routine work for the patients and did not exercise the same control over their treatment that the professionals did.

Anderson[27] found that most patients wanted to know the nurse on a personal basis. Johnson and Martin[28], in their study of the working relationship between doctors and nurses, made the point that the nurse fulfils the expressive relationship with the patient whilst the doctors are primarily concerned with prescribing the treatment after the diagnosis. It should, however, be noted that this division of labour relating to patient relationships is being fragmented even further as a result of nursing aides and auxiliaries taking over this aspect of the caring role in nursing (Burz[29]; Handschu[30] and Strauss[31]).

Nurses and patients

It has been well established that hospital workers who are in close contact with patients can experience role strain. Tomlin, in his study of nurses in intensive care wards, demonstrated that some nurses were more vulnerable to experiencing stress through their close involvement with patients. These nurses give their utmost to help patients to recover, but when a patient dies, nurses will be emotionally upset. This consultant argued that the conditions of

of work, with long periods of intensive involvement with patients, can be physically and mentally exhausting for some nurses[32].

Johnson and Martin recognised the importance of nurses who would manage the tensions that arise out of the medical treatment prescribed by the doctor. The nurse is perceived by them as the caring worker responsible for "providing the therapeutic environment for the patient which will take the form of creating a comfortable pleasant setting to the more directly relevant activities of explaining, reassuring, supporting and accepting the patient"[33]. Johnson and Martin did, however, express concern that the personal relationships aspect of caring work should be controlled by professional nurses and medicals. They realised that problems could arise in these relationships and that there were the risks of making the patient too dependent upon the sick role, and there was also the danger of the nurse being too expressive. Although the nurse must care about the patient as a person, she should not "allow herself to be too overtly involved with the patient, or she could not be professionally effective"[34].

We have learnt that one of the primary reasons for the loss of nurses in their training period is due to the emotional strains that result from involvement with patients (Davis and Olesen[35]).

The problem of professionals enacting their therapeutic role towards their clients has been thoroughly analysed by Halmos in his challenging work, *The Faith of the Counsellors*[36]. In this work Halmos examined the role strain which professionals had to cope with through their endeavour to be strictly objective in their attitude

towards the client yet experiencing a sense of emotional involvement. He strongly questioned the view that sympathy and emotional concern for the client would interfere with strict objectivity in the professional treatment provided. Halmos argued that it was essential that professional counsellors be good empathisers, that they should be sensitive to the personal needs of the client and that they should establish a rapport with them. He also argued that an affectionate concern for the patient could exist side by side with a keenly 'interested neutrality' for the correct treatment of the client. He did, however, warn that the professional had to control his involvement with the client. He should avoid self-indulgence and not exploit the professional function for self therapy. But Halmos asserted that there cannot be strict objectivity without sympathy because the lack of sympathy may distort objectivity.[37]

The important principle here is that love and fellow-feeling is a necessary quality for personal service workers, but it must be controlled. In my view, it is the control of personal feeling which is the source of role strain for personal service workers.

Halmos clearly illustrates the nature of the strain that social workers encounter in their relationships with the client. On the one hand the client needs love, warmth and affection. The social worker, committed to his client, will try to provide this emotional support. But he warned that the counsellor must not meddle or gratuously interfere with the personal integrity of the client.[38] The professional social worker has to balance both of these seemingly contradictory aspects of his role raltionship. There are dangers in emotional involvement if the professional worker

projects his own needs into the client's problem. But impersonal detachment can also be detrimental to the recovery of the client. Strauss also recognised the dangers of nurses intrajecting their anxieties into their relationships with their patients[39]. He also recognised the importance of personal relationships in psychotherapy treatment.

It has been well established by those sociologists who have investigated the personal service professionals that practioners in nursing, medicine and social work can be vulnerable to role strain as a result of their emotional involvement with the patients and clients they are concerned with (Anderson[40]; Halmos[41] and Johnson and Martin[42]). Strauss[43] found that nurses working with psychotherapists were vulnerable to role strain because they were familiar with the content of the psychotherapist's care of the patient, which was being administered because they were in closer and more frequent contact with the patient than the psychotherapists and they were much more involved in their personal problems. Strauss also argued that nurses were more vulnerable than their nursing aides because they had knowledge of the medical problems of the patient which the aides did not possess[44].

Johnson and Martin argued that the nurse had a more expressive role towards the patient than the doctors did[45]. The nurse was primarily concerned with providing the emotional support for patients whilst the doctor was responsible for diagnosing the patient's condition and prescribing the treatment.

The attributes of aides and ancillaries

Blum[46] and Richar[47] recognised that certain clients were vulnerable to insensitive handling by social workers. These sociologists were very much aware of the need for skilful empathic relationships and also that many lay workers had certain personal attributes, such as empathy. These qualities should be treasured and cultivated to reinforce the relationships that professionals establish with their clients. Indeed, there are those who argue that lay people in hospital situations may, in certain circumstances, establish more meaningful relationships with clients and patients. Blum[48], Carkhuff and Truax[49] and Strauss[50] stated that some lay people could reach out to people in need, and illustrated how they could be trained to use their empathic qualities in a purposeful way. Riessman has shown how lay workers have been selected and trained to work under the control and guidance of professional social workers to help the unemployed in the U.S.A. to cope with their problems and prepare for a new career[51].

Strauss has illustrated how certain psychotherapists build upon the personal relationships between hospital staff and patients. "Hospital personnel can serve as therapeutic agents in minor ways if they are interested enough in their patients. Some psychiatrists encourage personal relationships between staff and patients. Often the involvement is a matter of chance, but once this involvement is established the therapist capitalises on it".[52]

I am arguing that there are people who have personal qualities such as empathy, and have the capacity to talk to patients and to

help them. At present a situation exists where non-professionals get involved with patients and desire to sustain a personal relationship with them but cannot always be effective helpers. We can appreciate that training to develop and use these abilities would enrich their contribution to the care of the patient.

We can also understand the reluctance of many ancillaries to enter into a personal relationship with patients because 'they do not want to be involved'. This is a frank recognition of the strain that can exist in the hospital environment. It is reasonable to assume that a basic training to sensitise these ancillaries to deal with the problem of people who need emotional support can not only help them to face up to a strain but can also liberate some of the empathic qualities they may possess to help to reinforce the personal care provided by doctors and nurses. There is ample evidence that patients need emotional support (Anderson[53]; Burz [54]) and, according to Evans[55], that some patients can be alienated in the hospital environment. It is also recognised that the pressure on professional groups to become more involved in professional and administrative work can remove them from personal contact with patients, and this becomes a void which can be filled by ancillaries. Indeed, there are those who recognise that certain lay people can do this aspect of their work even more effectively than some of the professional and, in certain cases, are able to communicate with patients from the same economic and social group to which they themselves belong, an asset recognised by Riessman[56]. If this type of helping potential is recognised and cultivated and controlled by professionals, patients will be protected from those ancillaries

with good intentions who can undermine the recovery of the patients if they are emotionally upset by such involvement.

One can envisage different degrees of relationship between ancillaries and patients. We can consider the domestic who will occasionally bring her warmth and charm to establish a relationship with a difficult patient because an immediate rapport can be established between these two unique personalities. Such a relationship could be a breakthrough which others, such as professional and nursing groups, can build upon. This domestic can be the catalyst to win over the shy, anxious patient isolated in his new environment.

It is worth recalling the domestics referred to earlier in this chapter, who with their empathic and compassionate understanding were key figures in the much troubled intensive care ward and renal unit. The domestic who gave up one hour of her technical duties to assure the girl brought into the ward after attempted suicide that somebody cared about her, is an immense asset to the medical nursing team in the intensive care unit. The domestic could have neglected her cleaning tasks, but it is significant that the sister in the ward recognised that this domestic had certain qualities which were needed in this stressful situation and she made full use of these human resources to help a patient by giving the emotional support that was needed. We can describe many situations similar to the one cited because there are many ancillaries who are strongly motivated to comfort others and have rich empathic qualities which can be devoted to helping people in need.

If nurses can experience stress and strain in their relationships

with patients (Tomlin[57]), ancillaries, particularly those who have not been trained for this aspect of their work, can also be vulnerable in this respect. We also know that other personal service professionals experience role strain in this aspect of their work from the discussion of this problem in Chapter 1.

The relationship that the ancillary worker establishes with the patient is, in certain respects, similar to that which nursing and medical groups establish. Ancillaries may be involved in helping patients and in talking to them; a hospital porter who wheels a patient for occupational therapy treatment is directly contributing to the care of the patient and, like doctors and nurses who treat the patient, he will establish a personal relationship with him. The hospital porter who informs the patient that he will be wheeled to the therapy unit, helps him to sit in the wheelchair and takes him to the physiotherapy unit for treatment will have fulfilled the minimum requirement for this task. If the porter engages the patient in a friendly conversation, then he will have established a personal relationship which may or may not contribute to the care of the patient. If the porter engages in a conversation which will create a feeling of unrest, apprehension and anxiety in the mind of the patient, then this relationship can be damaging and will possibly undermine much of the good work done by medicals, nurses and physiotherapits. But, on the other hand, the porter can reassure the patient and assuage his anxiety. He is then reinforcing the work of the professional groups and is adding a further contribution to the wellbeing of the patient.

Porters and other ancillaries who empathise with patients in

this manner are, in my view, enlarging their roles beyond that defined in their job descriptions, which are predominantly concerned with their technical and manual work activities. If a hospital porter exceeds what is decreed to be his therapeutic role by giving advice on how a patient should behave which conflicts with medical professional advice, then he will lose a sense of propriety in his personal relationships. If the surgeon recommended to the patient an operation to remove a duodenal ulcer and the porter advised him to resist such an operation because he had cured his duodenal by self-treatment, or if the theatre assistant advised the patient about the result of an exploratory operation, this would be to exceed their role obligations to the patient through providing a sense of assurance that was not medically justified. If the domestic, in her endeavour to comfort a patient, talked too much about the various illnesses that other patients had experienced, this could provoke anxiety and a state of depression for the patient.

In each of the above cases, which were described to me by senior nursing staff, a genuine concern for patients by ancillaries could do more harm than good, yet if these ancillaries were correctly trained to use their genuine concern for their fellows in a more constructive manner, their efforts would genuinely contribute to the care of the patient.

To some extent, the stress that ancillary workers can experience can be attributed to their lack of preparation for this aspect of their roles. Unlike the professionals in medicine and nursing, most ancillary workers receive no specific training for this aspect of

of their role. It can, of course, be appreciated that these professional attitudes can be assimilated by the ancillaries through their association with professionals, and it is reasonable to assume that groups such as the theatre assistants who work closely with professionals will be more susceptible to these professional values than other ancillaries who are not so involved and should be able to cope with the stresses that arise out of their personal involvement with the patients.

We can note from Table 8 that theatre assistants were not as interested in knowing patients as other ancillaries were. It is necessary to consider some of the possible explanations for this more cautious attitude. A theatre assistant who discussed this problem said,

> "We don't spend much time with patients in their conscious state, and then only for brief periods, and in the main we only see them once. Those patients whom we see more than once are often those who undergo more than one operation, and usually they are patients with serious medical conditions".

Patient involvement is more evident when we consider those theatre assistants who are involved with patients in the after-care aspect of their work in the coronary care unit or the renal care unit, or when assistants are involved in local operations when patients are in a conscious state.

If we consider the domestics' and porters' attitudes towards personal involvement with patients, we can appreciate some of the reasons which have shaped these attitudes. The domestics were only

marginally more interested in patient involvement than the theatre assistants, although they met them in the wards when they were receiving treatment or recovering from a surgical operation. We have learnt in this study of the way in which domestics have contributed to the care of the patient through their involvement with them in the ward. Why, then, a reluctance for personal involvement with patients? There are two reasons which might contribute to the reluctance of domestics to want to know patients personally. The first reason is the pressure of work which domestics have to cope with, through their manual tasks in the ward, which militates against finding time for involvement with patients. The second reason is the stress that some domestics experience when dealing with sick patients.

The hospital porter's relationship with the patient is different in certain respects from that of other ancillaries. In contrast to the domestic, who is confined to work for long periods of time in one or two wards, porters are far more mobile and their work brings them into a wide range of contacts within the social network of the hospital. Domestics who are attached to specific wards are in more frequent contact with all of the ward patients than are the porters. Since porters are more mobile than domestics, they meet a wider range of patients. They can, however, establish a close relationship with certain individual patients whom they meet through the specific tasks they undertake for them, such as conveying patients to and from the physiotherapy unit. This type of relationship is a very individual, selective, personal and face-to-face relationship. A porter can meet one patient every day for a period of six weeks

and know him or her quite well, but his relationships with other patients can be more casual.

Porters, unlike domestics, are expected to possess certain social skills in their role. Indeed, it was recognised in the King Edward's Fund Report 1974, that porters are expected to converse and communicate with a wide range of people within the hospital, such as doctors, consultants, nurses, technicians, other ancillaries, patients and relatives. One can argue that these relationships and the pressures on the porter to co-operate with this diverse role set is conducive to the cultivation of a cordial pleasant, empathetic manner which is of particular importance as far as the patient is concerned. The responses of the ancillaries in Table 8 indicated that over half of the porters, domestics and ambulance workers wanted to know the patients on a casual basis, compared to a third of the theatre assistants who took this view and a quarter of the craftsmen. It is reasonable to infer from these findings that the three groups that are in most frequent contact with patients were more interested in knowing patients well, or casually, than were the theatre assistants. A reasonable explanation of the more reserved attitude of the theatre assistants is that much of their work brings them into contact with patients whose condition is often critical; where even a casual relationship might be stressful. Or, as explained earlier, the less frequent contact that theatre assistants have with patients does not provide a firm basis for establishing a close personal relationship with the patients.

We should not infer, however, from the responses of theatre

assistants who did not wish to know patients well or even casually, that they have no empathy with the patients. Indeed, Halmos[58] recognised the particular situation that surgeons were placed in when relating to the patients under their care. If, however, this is the case then there is a need to provide a less demanding definition of 'concerned empathy' to take into account the position of people in certain caring situations who are not in a position to establish the close personal relationships with patients and clients as envisaged by Halmos[59].

It is reasonable to assume that people in a wide variety of occupations can derive a strong degree of intrinsic satisfaction from helping people, even if they cannot be classified as personal service workers in the context defined by Halmos, who stressed the point that personal service workers were in occupations that were directly concerned with the physical and mental health of clients or patients[60]. The bus conductor can derive helping satisfaction and he or she should have the capacity to empathise with passengers. But the point made by Halmos about the special nature of helping occupations is a fair one because people employed in such work have a responsibility to consider the consequences of their attitudes or behaviour upon the patients' predicament as a helpee who is dependent upon the people in helping situations[61]. The bus conductor is not in this position and whilst it is pleasant for passengers to be dealt with in a friendly and respectful manner, the passenger is presumably in a similar position to the conductor in terms of general physical and mental health. Even if there are

differences, these are not relevant to the contractual relationship between the bus company and the passengers, except possibly in the special circumstances when the infirm or the elderly enter the bus.

The strain that ancillaries can experience through their relationships with patients is illustrated by the following comments:

Theatre assistant

> "I became very fond of a young girl with a heart condition. I used to talk a lot to her to cheer her up. She used to ask me about patients in a similar condition to hers and I used to reassure her. When she died after an operation I took it hard and I swore I would not get too involved again".

Theatre assistant

> "It's very stressful working in the theatre, particularly if a child is involved. We all have kiddies and it's difficult to be detached".

Porter

> "It's easy to get fond of a patient, and you can make favourites in the ward. Sometimes you can't help it - after all many porters marry female patients, like the nurses that marry male patients".

Ambulance worker

> "You can't help getting to like people, but sometimes you get upset when you see them failing in their health".

Porter

"You get to feel worry for a patient. You can't help it. I got to know a young man who got impaled by an iron bar when he drove his motor bike over a hole in the road, after the kids had removed the red lights. An iron bar went right through him, but he lived and I felt involved in helping him to get better. If he'd died, I would have become upset".

Domestic

"You can't help getting fond of some patients. They like to chat to you and tell you about their problems, and I tell them about mine and I think I am helping them but you get upset if anything happens to them".

Porter

"I met my wife in hospital so you can't help liking the patients".

Theatre Assistant

"When I meet patients in the intensive care unit, you have to guard against your feelings. It's one thing I learnt from the nurses and the doctors. Don't let your feelings get the better of you".

Ambulance worker

"You can't get too involved with your patients, you just couldn't stand it. You have to stand back from them, but that doesn't mean I am not concerned about them as people".

Domestic

"You find that you are not only concerned about the patients,

but about their families. If they have children you share a patient's concern for them".

These comments help to describe the significance of the statistics concerning personal involvement with patients. They also illustrate the dilemma of non-professionals who find that their fellow feeling extends beyond solidaristic type relationships with their work companions into the lives of the patients. We can appreciate from the statistics and comments that there are many people who, as Halmos has suggested, bring personal qualities to their role.[62] Many ancillaries provide a rich source of love, sympathy and empathy but they are afraid, and very often ill-equipped, to put this much desired asset to full use.

Anderson[63] illustrated the concern which nurses and patients placed upon emotional support. The most common words used to express the specific type of support needed were; kindness, understanding, patience, tenderness, availability, gentleness, consolation. Similar findings were established by Handschu in her study of nursing aides in geriatric hospitals, "Many aides felt that love, patience, understanding, were the most important qualities of a good aide".[64]

When we consider the nature of the role strains that arise out of the ancillary's relationships with the patient, we can clearly see the paradox of people wanting to help others, of wanting a personal relationship with a patient, yet restrained by the caution of not wanting to become too emotionally involved with him or her. This type of strain has been recognised by sociologists concerned

with the personal services (Hayward[65]; Strausse[66]).

The ancillary's relationships with patients may not be as close or intense as those which counsellors and personal service professionals in social work or nursing establish with their helpees, but the strain can be even greater when we consider that training is not provided for most ancillaries to deal with this aspect of their work. This could be attributed to the narrow vision of the administrators and the reluctance of the personal service professionals to develop the potential of aides and ancillaries to empathise with people in need. Domestics, porters and other ancillary workers establish personal relationships with patients. The cook in the hospital who baked a cake for a patient on his 80th birthday, the domestic who accommodated the son of a dying patient in her home to save the cost of hotel accommodation - these are just two examples of the desire to help people which ancillary workers have.

We need to pay much more attention to the view that lay personnel in hospitals can, in certain circumstances, establish a more meaningful relationship with patients than some of the professionals. One needs to consider the view of Halmos[67] and others that some people possess the attributes of empathy and that these people should be encouraged to help those in need.

I have described the importance that personal service sociologists have attached to empathising with patients and I have also described the nature of the empathising relationship that ancillaries established with patients. In Chapter 3 I focused upon the extent

to which ancillaries wanted to know patients and found that most of the ancillaries wanted to know the patients well or knew them well. I also established that there were some who did not want to know patients and this was particularly the case with theatre assistants. I anticipated that some ancillaries would not want to know the patients because it might be stressful. So I presented them with a supplementary question which invited the ancillaries to indicate the extent to which they did not want to know patients because it might be stressful and the responses to this question are presented in Table 16.

TABLE 16

THE EXTENT TO WHICH ANCILLARIES DID NOT WANT TO BE INVOLVED WITH PATIENTS

KNOWING PATIENTS IS STRESSFUL	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Like to know well	20	10	26	15	8
Like to know casually	52	53	60	64	50
Don't want to be involved	28	37	14	21	42
	100	100	100	100	100
Ancillaries responding (= 100%)	25	32	35	39	

$X^2 = 9.23$ C = 0.23 Not significant at 0.05 for d f 4*

(* adjustment to cells)

We can see from the above table that the theatre assistants emerged as the occupational group who perceived patient relationships

to be quite stressful. If we combine the data in Table 16 with those in Table 8 referred to in Chapter 3, which was concerned with 'Wanting to know the patient', then this should enable us to measure the component of role strain related to the second value of personal service orientation, concerned empathy.

Measuring role strain

I have examined the conflicts that ancillaries experienced in their work and in their relationships with nurses. I have also examined the strain that they experienced in their relationships with patients. I am now in a position to calculate the overall degree of role strain experienced by ancillaries. If I determine the mean average score for the four components of role strain this will enable me to consider the extent to which theatre assistants differed from other ancillaries. In the context of the Halmos hypothesis, it is reasonable to assume that theatre assistants should experience less role strain than other ancillaries because they work more closely with the professional groups than other ancillaries do. If we refer to Table 17 below, we can compute the mean average score for the four role strain components and also compute the overall measure of role strain.

TABLE 17

THE DEGREE OF ROLE STRAIN EXPERIENCED BY FIVE ANCILLARY OCCUPATIONAL GROUPS (MEAN AVERAGE SCORES)

DEGREE OF ROLE STRAIN EXPERIENCED	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFT (n = 26)
Role conflict	2.65	2.05	2.1	1.92	1.08
Nurses awareness	2.15	2.13	2.1	2.02	2.3
Do more for patient	1.9	1.3	1.56	1.3	1.9
Patient involvement	2.1	2.4	1.8	2.08	2.23
Total score	8.8	7.88	8.06	7.32	7.5
Mean average score	2.2	1.95	2.02	1.8	1.88

F = 3.76 Significant at 0.05 for d f 4 and 136

It is evident from the data in Table 17 that, on the basis of an analysis of variance test, there was no significant differences between the occupational groups in the overall degree of role strain experienced. If we refer to Tables A6 in Appendix A, we can also consider the relationship between role strain and the age group to which the ancillary worker belongs. We again find that there is no significant difference between the degree of role strain experienced by the three age groups. The data in Table 17 suggests some support for the hypothesis that theatre assistants, the group most closely involved with medicals and nurses, experienced a marginally lower degree of role strain than ambulance workers and porters. But it is also worth noting that the domestics experienced the lowest degree of role strain. A possible explanation for the position of the domestics is that they are less concerned about their status or about intrinsic involvement than the other ancillary groups who were predominantly males.

When I considered the relationship between role strain and intrinsic involvement, I wanted to test the hypothesis that there would be a close association between low role strain and high intrinsic involvement for the theatre assistants because they were more closely involved in a personal service professional culture which would support the ancillaries working within it.

In Table 18 we can see that there was no close association of the type envisaged when I focused upon all of the ancillaries in the survey. It is evident that a medium degree of role strain was associated with a medium degree of intrinsic involvement. When I focused upon the theatre assistants who were embraced in this table, I found that, of the small minority of ancillaries who ex-

perienced a high degree of role strain together with a high degree of intrinsic involvement, all were theatre assistants. It is also interesting that the five theatre assistants in this category worked in the large teaching hospital. This finding suggests that personal service professional work cultures are not always supportive and that aides and ancillaries might have to struggle to become intrinsically involved in their work.

Intrinsic involvement and role strain

If we consider the nature of the relationship between the experiencing of role strain andthe expression of intrinsic involvement in work, we can test the hypothesis that theatre assistants who were in more frequent contact with medical and nursing groups than the other ancillaries would experience the lowest degree of role strain. The nature of the relationship between these two groups of work variables is illustrated in Table 19 and a more detailed analysis can be referred to in Table 5 in Appendix A.

TABLE 18

THE RELATIONSHIP BETWEEN INTRINSIC INVOLVEMENT IN WORK AND ROLE STRAIN FOR ALL ANCILLARY WORKERS

(PERCENTAGING TO OVERALL GRAND TOTAL)

ROLE STRAIN IN WORK	INTRINSIC INVOLVEMENT IN WORK: HIGH	MEDIUM	LOW	ALL ANCILLARIES ROW TOTALS
Low	1.5% N = 2	15.5% N = 20	11.6% N = 15	28.6% N = 37
Medium	5.4% N = 7	37.2% N = 48	13.9% N = 18	56.5% N = 73
High	3.8% N = 5	10.1% N = 13	0.7% N = 1	14.9% N = 19
Column Totals	10.7% N = 14	62.8% N = 81	26.2% N = 34	100% N = 129

$X^2 = 11.2$ C = 0.28 Significant for 0.05 for d f 4

We can see from Table 18 that there is no strong association between role strain and intrinsic involvement for all ancillary workers. What is very significant is that there is a close association between the experiencing of a medium degree of role strain and the expression of a medium degree of intrinsic involvement in work. It is, however, interesting to note from the above table that *all of the ancillaries* who expressed a high degree of intrinsic involvement in work and a high degree of role strain were theatre assistants. This finding does not substantiate the hypothesis that theatre assistants would experience a lower degree of role strain than those ancillaries who are not so closely involved with medical and nursing groups. Support for this hypothesis is also weakened by the finding that of the 19 ancillaries who experienced a high degree of role strain, five of them were theatre assistants and all worked in the large teaching hospital.

Personal service orientation

I will now consider the extent to which the ancillaries can be defined as personal service orientated in accordance with the Halmos criteria.

In Table 19 I have endeavoured to measure the degree of personal service orientation expressed by the ancillaries. I have sub-divided them into three categories of personal service orientation. The ancillaries who had high scores on the fifteen work activities that I considered to be indicative of the three values of personal service orientation are considered to have expressed a high degree of personal service orientation. Those with

low scores are considered to have a low orientation and those in the intermediate position to express a medium degree of orientation.

TABLE 19

THE DEGREE OF PERSONAL SERVICE ORIENTATION EXPRESSED BY ANCILLARIES

DEGREE OF PERSONAL SERVICE ORIENTATION	OCCUPATIONAL GROUPS					
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)	
	PERCENTAGING TO COLUMN TOTALS AS A BASE					
	%	%	%	%	%	
High	0	10	4	15	0	
Medium	63	78	58	67	46	
Low	37	12	38	18	56	
ANCILLARIES RESPONDING (= 100%)	100 19	100 33	100 26	100 7	100 9	94

X^2 = 10.16 C = 0.31 Significant at 0.05 for d f 4*

*(adjustment to cells)

It is evident from the above table that only a very small minority of ancillaries can be defined as highly personal service orientated. If we focus upon this small percentage, we can note that the domestics were the most prominent, but in view of the small number in this group who responded to the relevant questions, this figure should be regarded with caution. What is significant, is that the theatre assistants were only marginally more prominent than the porters in this category. Only if we consider the high and medium orientated categories can we consider the theatre assistants to be the most strongly personal service orientated ancillaries.

Summary

In this chapter I established that only a small percentage of

ancillaries experienced a high degree of role strain. Most of them experienced a medium or low degree of role strain. I also established that there were no significant differences between the occupational groups in respect of the degree of role strain experienced. I did not find firm evidence to support the Halmos hypothesis, that theatre assistants should experience a lower degree of role strain than those ancillaries who were not so closely involved in a personal service professional culture, such as the operating department.[68] Neither did I find that theatre assistants experienced a high degree of intrinsic involvement associated with a low degree of role strain. But I noted that theatre assistants who worked in the teaching hospital were highly intrinsically involved whilst experiencing a high degree of role strain.

In this chapter I endeavoured to measure the degree of personal service orientation expressed by those ancillaries who responded to those questions that I considered to be related to the components of the three values. I found that only a small percentage of ancillaries expressed a high degree of personal service orientation and that theatre assistants were not particularly prominent in this category. This finding did not provide strong support for the hypothesis presented by Halmos about the supportive personal service professional culture[69]. Having focused upon the intrinsic aspects of the ancillary workers' role in Chapters Three, Four and Five, I will focus upon other aspects of the ancillaries' aspirations which are relevant to the concept of

personal service orientation in the next chapter, when I examine their concern about their occupational status in hospitals and material rewards.

CHAPTER SIX

THE SOCIAL AND ECONOMIC ASPIRATIONS OF ANCILLARIES

In the previous chapters I have described the nature of the ancillaries' work, I have examined the nature of their work involvement and I have examined their relationships with medical and nursing groups. I have also examined the degree of role strain that ancillaries experienced in their work.

In this chapter, I will consider the aspirations of ancillaries in respect of their occupational identity and status in hospitals. I will also examine their aspirations to improve their wages, salaries and conditions of service.

In Chapters Four and Five I described the ancillary workers' concern about their low status. The ancillaries were conscious of their contribution to patient care and wanted to be recognised for it by medical and nursing groups. They wanted to be part of a caring team, such as a ward or operating department team. Some of them, for instance the theatre assistants, wanted to belong to a team but retain a separate occupational identity within it.

Theatre assistants and ambulance workers have strong aspirations to achieve para-medical professional status. They also share with nurses and other groups a strong concern for more tangible rewards for their work, which they maintain is grossly underpaid relative to the monetary rewards of manual and non-manual workers outside the NHS. They want a share in the modest prosperity provided by an increase in economic growth in the United Kingdom.

One of the main characteristics of the personal service culture is the concern that personal service workers ought to have about their involvement in strike actions. Halmos recognised that personal service workers were entitled to wages and salaries that would attract them to caring work and sustain them in it, but he argued that the commitment to serve others should be their dominant value.[1] This commitment, however, presents problems to personal service workers, who are not in a position to resort to industrial sanctions to improve their position without the risk of harming their clients or patients. The nurses, particularly those who belong to the Royal College of Nursing (RCN), have argued very strongly against any form of industrial action that might harm the patients. Indeed, their conduct during the many industrial disputes that have emerged in the last decade has been consistent with their policy towards industrial sanctions.

The norms of hospital sub-cultures have tended to oppose the use of industrial sanctions, particularly in the form of strike action. The increasing number of strikes and other forms of sanctions indicate that these norms are being challenged. They have certainly been challenged by the ancillary workers, where many of them have had industrial experience and the experience of industrial sanctions.

In this chapter, I will examine the way in which theatre assistants and other ancillaries have endeavoured to improve their occupational status and living standards.

Occupational identity and status

Ancillary workers are concerned about their status. Theatre workers have strong aspirations to become para-medical professionals. There is also an increasing interest in this respect with ambulance workers. Theatre ancillaries participate in the highly orientated professional culture of the operating department and want to be recognised in this situation. Not only are they concerned about work satisfaction and monetary reward, they want the status they feel entitled to.

There are two ways that ancillaries who are recognised theatre assistants are adopting to achieve recognition. First, they are working through their trade unions to have their wages and conditions of service negotiated through the Whitley Staff Professional Council, where they will be grouped with pharmacists and other medical technical groups instead of through the Whitley Staff Ancillary Functional Council. Secondly, they are working through the professional association that they have formed, which is now known as The British Association of Operating Department Assistants. This association is concerned with standards of training, the quality of patient care and the development of a career structure. The Association is concerned, too, with establishing its own register of qualified members and seeks to be validated in the community as a legitimate para-medical profession.

Through their Association, the theatre assistants are working as a pressure group to win the support of the Department of Health and Social Security, hospital administrators, anaesthetists, surgeons

and nurses. The association has its own journal, *Technic*, and this is concerned with educating members on medical, surgical and professional matters, and with communicating with other professional workers in the hospital service.

Ambulance workers are also pursuing professional recognition. They are working to improve their status through the Ambulance Service Institute. This association arranges correspondence courses to enable ambulance workers to be accepted as associate members leading to a fellowship of the Institute. The association produces its own journal, *Ambulance Journal*, which discusses such questions as medical developments and patient care matters, and questions concerned with professional status. Another important development was the formation, in 1978, of The Association of Emergency Medical Technicians.

In these ancillary occupations, there are those with strong aspirations to obtain some form of para-medical status. This can be viewed as a desire for recognition in a sub culture dominated by professional groups with varying degrees of status. It appears that ambulance and theatre assistants see themselves at the bottom of the status hierarchy and are striving to improve their relative position in it. This also indicates that ancillary workers like others in the NHS seek some recognition for their contribution to patient care.

There is considerable evidence from the reports of occupational associations and their journals, *Technic* for theatre assistants and the *Ambulance Journal* for ambulance workers, and also from trade

union journals, about the concern of these ancillaries about this problem. Whilst the domestics and porters are less concerned about status recognition, there are developments that are encouraging ancillaries such as domestic supervisors and head porters to improve their positions.

Domestic supervisors are encouraged to pursue the City and Guilds qualification in domestic science. They can also pursue a City and Guilds course known as N.E.B.S.S. (National Examination Board of Supervisory Studies) to acquire supervisory knowledge and skills. This supervisors' course is also available for Head Porters and for other ancillary supervisors. Head Porters have also formed their association which is concerned with improving their status.

What is important, is that ancillaries who want to improve their status should have a career structure and training opportunities to provide the relevant knowledge and skills. At present, porters are graded but have no career structure, neither have the domestics. Theatre assistants have limited training opportunities and some form of career structure, but their position is often uncertain and they depend a great deal on whether they are accepted by nurses and the medicals in the operating departments. Ambulance workers can study to improve their qualifications through a correspondence course, but even if they become members or fellows of the Emergency Medical Technicians' Association, their main career prospects are through obtaining a management position in the control office.

We need, of course, to understand the extent to which theatre

assistants and ambulance workers are changing their occupational identity and becoming para or sub-professional groups. Carr Saunders[2] defines a profession as an occupation based upon specialised intellectual study and training, the purpose of which is to supply a skilled service for others for a definite fee or salary.

Greenwood , in his sociological analysis of the common attributes of professional, distinguished from non-profeesional, elements, stated that there are five main elements which most professional bodies agree upon as the distinguishing professional elements. These are: systematic theory, authority, community sanction, ethical codes and a culture. Many of these elements are included in the work role of certain non-professional occupations to a greater or lesser degree[3].

It is important to ask the question as to what extent theatre assistants emerge as a professional body. As a result of the Lewin Report and the recently structured City and Guilds course for theatre assistants, there is quite clearly a fund of knowledge that they will acquire. They will also be taught to accept the ethical values and commitments which guide the professional groups in their hospital work. They will be influenced by the ideals and values which will be largely determined by the micro culture of the operating theatre work environment. The responsibility for training and validating the qualifications of the theatre assistants will rest in the hands of the medical groups.

There are theatre assistants and ambulance workers who perceive

their role as para-medical workers. Para-medical workers have been defined by Green as groups of workers whose work is organised around the treatment of patients and who, largely because of this, are ultimately controlled by doctors[4]. Their knowledge is derived from the medical profession. They perform tasks which are of assistance to medical staff. They are not involved in the task of diagnosis but they help the physician to fulfil these functions.

Green argues that para-medicals are concerned about developing and improving their own position relative to the medicals. They are concerned about exercising autonomous decisions and they are being selective about accepting people into this work. They are concerned about building up prestige and improving their occupational status[5].

Theatre assistants are acquiring knowledge and skill for specialist work. Their teaching is under the supervision of medical groups. Their work is concerned with treating the patient but they are under the control of medicals and their knowledge is derived from the medical profession. They perform tasks which are of assistance to medicals and support the physician and surgeon in diagnosing illness and they support the work of the anaesthetist.

The ambulance worker is not as well trained as the theatre assistant. Their teaching is supervised by medicals. They accept the ethical code to some degree but, unlike the theatre assistant, they have more autonomy in patient care decisions. They make a diagnosis when the doctor is not available and act on this decision until a patient is taken to the hospital.

In terms of these criteria, ambulance workers and theatre assistants cannot be categorised as professional groups. The question arises - to what extent can they be compared with the para-medicals? The title 'para' suggests that these groups are ancillary to the medical profession and that they are sheltered by the authority which medicals possess in the hospital world. Let us consider the position of these groups.

Theatre assistants

I have referred to comments expressed by theatre assistants about their concern over their status in this chapter. I will now refer to some of the comments that they have expressed on this question in their journal, *Technic*.[6]

F. G. Hemer, in September 1979 :

> I am convinced if not for some far sighted people in the early years we would still be known as 'Good Porters' and not accepted as most of us have been as accredited members of the team.

J. A. Riley, in January 1982 :

> Let us look at the title most of us though would succeed that of attendant ... Technician. A technician is defined as a person skilled in the technicalities of some subject or the technique of some art or science. Or are we just assistants, that is, one who assists or helps, though one other definition states: 'a person who assists or helps in a lower position'. How low is low?

J. A. Davies, in February 1973 :

> Technicians only want to be recognised for the skilled work they carry out and their part in the theatre team and receive a realistic remuneration.

The comments that the theatre assistants have expressed about

their occupational identity illustrates the point that Becker and Carper made. They argued that there are four major elements of work identification. These were an occupational title and associated ideology, commitment to task, commitment to particular organisations and institutions and significance for one's position in the larger society[7].

Theatre assistants want to identify themselves with the caring ideology that they are concerned that their occupational title reflects the importance of their work with its skills and responsibilities. They see themselves as members of the theatre team working with medical and nursing groups. They are also stressing their commitment to this team, which might be considered to be one of the most important in the hospital.

The struggle of the theatre assistant for recognition in the professional milieu of the operating department illustrates the type of role strain that Wilensky[8] recognised. He described the way in which groups who strove for professional status within a professional milieu achieved such status. He pointed out how they formed a Teaching School under the tutelage of recognised professionals who were responsible for examining and validating their courses and provided accreditation. The theatre assistants formed their first school in Guildford in 1963 and it was supported by senior medical and nursing theatre personnel. Here they could study for the Diploma of the Institute of Operating Technicians. Today, there are many teaching schools throughout the United Kingdom and theatre assistants can qualify for a recognised City and Guilds

Certificate. Theatre assistants can also belong to the British Association of Operating Department Assistants (they were previously an Association of Operating Assistants).

Wilensky[9] also referred to the 'hard competition' that aspiring professional groups had to enter with those in 'neighbouring occupations'. This problem is one that is encountered by theatre assistants in their relationships with the theatre nurses and is illustrated by two comments expressed by theatre assistants.

J. A. Davies, writing in *Technic*, February 1973 :

> Members of the Theatre Nurses Association seem to be very nervous the technicians aim for improved status may jeopardise their position. This fear is obviously unfounded.[10]

M. M. Williams made this point in the *Nursing Mirror* in March, 1979 :

> ODAs do not seek entry into a 'caring profession'. They are members of it - all they want is recognition of that fact.[11]

It will be interesting to consider the way in which the theatre assistants were involved in negotiating their position in the hospital organisational structure.

Negotiating para-professional status: the theatre assistants. It has been well-established that there are only limited opportunities for ancillary workers to influence decisions that relate to their immediate work environment. McArthy[12] has noted that the opportunities that existed within the Whitley structure for joint consultation in hospital had not been widely used.

Ambulance workers can rightly be regarded as the most successful of the non professionals in the health service to establish formal

consultation procedures and it is worth noting that these procedures had often emerged out of the various disputes that ambulance workers had been involved in with their Area Health Authorities. Sometimes these formal procedures were introduced as a result of specific recommendations made by the Arbitration and Conciliation Advisory Service, as in the case of the procedures established for ambulance workers in South Glamorgan in 1974.

When we consider the position of theatre assistants, we find that there were very few opportunities for them to be involved in consultation or participatory procedures. In many cases this was due to the dual role that theatre assistants were placed in. They were often in a position where they would be responsible to the nursing officer in charge of the theatres for their work in the operating department. But they would be responsible to the head porter or unit administrator for the contractual aspects of their work because they were ancillary workers. In this situation, theatre assistants were in a position where they were not closely involved with their ancillary supervisors because they were not part of his or her work team. If there was no formal joint consultation committee, the theatre assistants would probably have been deprived of the opportunities for them to be consulted by their ancillary supervisors, either formally or informally. When we consider their position in the operating department, a great deal would depend upon the extent to which the nursing officers would involve them in discussing problems relating to their work situation.

It is also important to note that joint consultative committees

and other forms of workplace participation have provided opportunities for non professional workers to negotiate on such local issues as overtime payment, overtime working, manning arrangements and various problems that were causes of concern. This was certainly the case with ambulance workers who were occasionally criticised by managers, and indeed by A.C.A.S. for using consultative machinery for negotiations on local issues. In many instances, arrangements were made by ambulance workers for local negotiations to take place. The whole question of local negotiations is one that was given considerable emphasis in the McArthy Report of 1977, and although the recommendations relating to this problem have not been implemented on a large scale, it is reasonable to assume that it is a problem which will command attention in the future.

Although there is no firm evidence to suggest that theatre assistants have developed special arrangements for consultation and local negotiation, it may be assumed that, in view of the controversial nature of their position, they have been involved in informal negotiations. Strauss[13] has indicated the way in which non professionals have had to negotiate their roles with medical and nursing groups and it can be expected that theatre assistants will also try to influence decisions in a similar way.

It is interesting to note that, where there have been strained relationships between nurses and theatre assistants, agreements have been made which have been of particular relevance to theatre assistants. In 1979, a committee was set up in the Dulwich Area Health Authority, to resolve many of the problems that caused the theatre nurses there to walk out in protest about the way in which

theatre assistants had been employed in the operating theatre in the hospital concerned. The report of this committee indicated the nature of the problem that had to be resolved. There were two aspects of the report which were presented to an Area Management Team for action which, in my view, reflect the understanding that had been arrived at to solve the problem of managing operating theatre departments. First, the committee recommended that "The key role to day management of the operating department is undoubtedly that of the nursing officer in charge, who is considered to be in charge of all staff working in the operating theatre". The report also recommended the formation of a Theatre Users Committee, which would include medical nursing, administrative staff and "a representative of non medical/non nursing staff working in theatres" (a theatre assistant).

The second group of recommendations that are of interest refer specifically to the theatre assistants and theatre orderlies. It was recommended that they be directly responsible to the nursing officer in charge, although it recognised the problem of the theatre assistants who were responsible to the head porter on contractual matters, and urged a closer liaison between the nursing officer and the head porter, particularly on disciplinary issues. Recommendations were also made on the ratio of nursing staff to theatre assistants and the need for flexibility in manning arrangements between these groups in accordance with the recruitment market for theatre nurses. The committee also recognised that "newly appointed Operating Department and Senior Operating Department Assistants should automatically be allowed to *scrub up*, unless

previously given a contract solely for the anaesthetic room".

Whilst the committee making this report did not include a representative of the theatre assistants, it is evident that they did exert some influence in shaping decisions that provided them with scope to develop and apply their skills in theatre work. It also provides them with opportunities, even if of a limited nature, to participate in a Theatre Users Committee, where they can provide some contribution to the work of the operating department.

In spite of the efforts of the theatre assistants to upgrade their skills and achieve some degree of professional status, they have received a setback which has been very disappointing to them. In 1982, a job evaluation report which had been established to evaluate the validity of the case of the theatre assistants to leave the Ancillary Staff Functional Council to join the Professional and Technical Council 'B' Functional Council, could not recommend such a move. They could not support the view presented by the theatre assistants that their work was comparable to that of Physiological Measurement Technicians.

This report outlined that the theatre assistants did not fulfil the expectations of the Lewin Report of 1971. The report recognised that theatre assistants played a key supportive role to the anaesthetist but they were not so closely involved in supporting the surgeons. The report made this significant point:

> It was less common to find the O.D.A. preparing the theatre itself and its equipment and assisting the surgeon .... These duties were undertaken less frequently either because it was a hospital's policy that they were performed by nurses only,

> or that it necessitated a second O.D.A. or other trained person to be available to assist the anaesthetist.[14]

The implications of this report are clear. It makes the point that, whilst the area of supporting the anaesthetist has not been a source of controversy with the theatre nurses, this is not the case in the surgical area. This finding tends to support the view that I have presented in this study, that theatre nurses are not convinced that their position is not being threatened by the up-grading of the skills of theatre assistants. It also suggests that the opportunities to apply surgical skills and knowledge have not been encouraged by theatre nurses, in spite of the need to develop them through practical experience in the hospital operating departments.

The findings of the job evaluation team might well reflect the fact that there are those personal service professional groups who will not encourage subordinate groups to maximise their role performance if these groups are seen to threaten the position that they have strived for over the years. The findings also suggest that no evidence could be found, on the basis of a study of seven hospitals, that theatre assistants were not capable of maximising their potential, but rather that they were not allowed to. The report also recognised that because theatre assistants were not as well trained as physiological technicians (a comparative group) they were not entitled to belong to the Professional B Functional Council. The only group that they could rightly be associated with were the nurses, but this would not be a practical solution and the panel made this significant point when referring to the most suitable

Functional Council for theatre assistants, "If it were possible to consider the situation without taking any other factor into account than job similarity, we could have recommended that the nurses and midwives' structure offered the most appropriate comparators in principle, but not in current common practice in the operating theatres; if transfer to the nurses and midwives' Council were contemplated (and the question was asked of us) we could not recommend a higher basic grade than one equivalent to the basic grade of an equivalent broadly to the S.E.N."

'When we consider that the Royal College of Nurses has just published a policy document* on the future of nursing and that one of the recommendations is about phasing out the S.E.N. in the long term, one can appreciate that theatre assistants might be reluctant to base their future within the nursing structure.[15]

The nature of the problem is a political one which suggests that the operating department is not a homogeneous work team but typifies Esland's view of "alliances of smaller occupational specialisms" and "that there are inevitably issues over which different segments are in competition with one another"[16].

It is also interesting to note the point Esland made about campaigns of mutual denigration between conflicting groups has also characterised the strained relationships between nurses and theatre assistants.[17]

* The Development of Nurses Education Working Group 3, Consultation Paper 1, 1982, by U.K. Central Council for Nursing, Midwifery and Health Visiting

Ambulance workers

There are a substantial number of ambulance workers who want to enlarge their role. They want more medical knowledge and skills. There are three specific areas where they feel that they can do more for the patient. They can relieve a doctor from such tasks as infusions, blood transfusions and intravenous. They can do more by having the authority to inject patients. They can do more in cardiac treatment for the patient. There are already some districts where this work is being done. A letter in the correspondence column of the *Sunday Times* made this point (April 29th, 1977).

> "Ambulance drivers can be doctors too
>
> I agree with what Oliver Gillie writes in his article 'Where nurses can be doctors' (Leader Page, last week). But why does everybody forget the Ambulance Service?
>
> Ambulance men can ease hospitals' work by giving patients proper 'immediate care'. Some areas have realised this potential and have trained their accident and emergency crews in intubation and intravenous infusion. Elsehwere, ambulancemen are shown the procedures used in cardiac ambulances. There is absolutely nothing to stop all crewmen being trained in these life-saving methods. Why make the nurses into something special and forget the potential of the ambulance worker?
>
> Ambulance crews must be in a position to decide whether a person should go to hospital or not. They must make a good preliminary diagnosis and, in most cases, they might be able to treat the patient well enough for the Casualty Department to have little or no work to do. This means that the knowledge of how to intubate, infuse, give drugs, read ECGs and defibrillate must be available to ambulancemen nationwide.
>
> Operational ambulancemen, especially new men, should go through a course leading to State Registration. Nurses have to do it to protect themselves, so why not ambulancemen? A higher educational standard should be expected from all new entrants into the ambulance service. The Institute of Certified Ambulance Personnel must be universally recognised as the ambulanceman's professional body and must have a total say in medically orientated ambulancemens' training.

The days are now gone when ambulancemen threw their patients into stretchers and rushed them to hospital, killing most of them on the way by mismanagement and incompetence. Daily we become more professional, but we are still open to attack from the petty jealousies of some doctors and nurses.

Doctors agree that the better the treatment, and the earlier it takes place, the better the patient's chances of recovery. An ambulance should be in effect the Casualty Department coming to the accident or emergency

(Ambulanceman) Peter T. W. Brown, Belfast.

A similar view was expressed in the COHSE conference of 1976

Training for ambulancemen

The general public demands and receives of the ambulanceman total dedication to the service. He must be a responsible, well-adjusted person, able to cope with any emergency with compassion and understanding, able to put his patients first and have the competence to deal with the violent mental patient or the person trapped beneath a car, lorry or train alike. He must be a person who can look after the chronic sick, the malingerer, the junkie and the burned or battered child; who can deliver the impatient mother of her child and settle family arguments; who can be kind and gentle to the newly bereaved when all his skill and speed have not managed to work the 'mini-miracle' that has come to be taken for granted. He transports those who will never recover, the highly infectious, or simply old Mrs. Brown for her daily hospital meal. In between times he cleans and refuels the ambulance, and all in a shift system which is without meal-breaks if necessary.

And, what do we, the ambulancemen, demand of society in return? - a *standardised*, *national* ambulance service! We demand a standard of training that will bring to the patient a qualified, paramedical ambulanceman properly trained in teaching hospitals throughout the country in paramedical emergency medicine. A qualified doctor is not always to hand at the scene of an accident, and with the necessary paramedical knowledge, the ambulanceman could often be instrumental in the saving of life by means other than the competent handling and swift transportation of the patient to hospital. Moreover, he could provide casualty staff with a concise report on the patient's condition, thus assisting already overburdened casualty staff in their work.

There was also a lengthy debate at this conference about the

professional status of the operating theatre technicians. The conference supported the case of the executive committee of COHSE, put by Mr. Terry Mallison, that the future professional standards of the theatre technicians lay in a recognised qualification and training, such as the City and Guilds examination and training. The conference had a duty to maintain *professional* standards.

It is very interesting to note that access to these two important occupations has not been confined to those with minimal educational qualifications. Selection has been based on the personal qualities of the applicant. It is, however, evident in the case of the theatre assistant that new entrants are now being selected who have basic qualifications, such as four GCE 'O' level subjects. These new entrants will be better equipped to take the examination than those who are already in this work. Of the older assistants who have been placed on the training course of the City and Guilds - Hospital Operating Department Assistants Certificate - many of them are having difficulty in studying to pass their examination when they are studying for only six hours a week over two years, and their study period will often follow an intensive work day in the hospital.

When we consider the ambulance worker, we find that a minority of them are studying by correspondence course to become members of the Institute of Certified Ambulance Personnel, but unfortunately, no time is allowed during the working week for such studies. We can assume that, with more emphasis being placed on training for

a highly demanding work, the occupational identity of theatre assistants and ambulance workers will change from a manual ancillary occupation to a paramedical profession. The elements of professionalism exist in both occupations. These are specialist training and recognition of ethical obligations concerning patient care. Much of their knowledge and training is derived from the medical profession. We can appreciate the structure of the training of the theatre assistant by referring to the City and Guilds syllabus prepared for them which is shown in Appendix F.

The Lewin Report (1970) suggested that candidates for entry to this new occupation should possess a satisfactory level of general education as well as certain personal qualities that the theatre assistant should have. The Report appreciated that very often well-educated assistants were not always suitable because they lacked certain 'practical aptitude' and 'an equitable disposition'. But the Lewin Report stressed the importance of theatre assistants. They 'should have an acceptable standard of intelligence and level of literacy compatible with their being able to understand lectures and sit written examinations'.[18]

I suggest that the Lewin Report represents the beginning of paramedical professionalism for a group of workers who have been traditionally regarded as manual workers and who were often classified as hospital porters.

The importance of providing a more extensive training for ambulance workers has been recognised since 1963, when a working party under the chairmanship of E. L. M. Millar examined the training

needs of ambulance workers and published its report in 1966[19]. This report recognised that training opportunities and facilities were extremely limited and recommended the introduction of an 8 week training on a full-time basis for all new entrants, followed by operational duties during which they would have a week's secondment to an accident and emergency department in a selected hospital. They would be tested at the end of the year for the Ambulance Service Proficiency Certificate.

There is some evidence that the ambulance worker is being prepared for a more professional role and is more closely involved with a professional work team. In the Frenchay Hospital District of Bristol, the hospital doctors and nurses, together with ambulance workers, co-operated to provide a scheme designed to deal with serious emergency cases. This work was pioneered by Dr. P. J. F. Baskett.[20] The outline of the scheme was,

1. To provide a comprehensive and skilled resuscitation service within the area served by the hospital for all patients requiring resuscitation regardless of the underlying disease or injury.

2. To *train* ambulance men in both the basic and *sophisticated techniques* of resuscitation to *enhance* their *diagnostic* skills and to bring together the ambulance and hospital services in their *common objective* of *patient care*.

Ambulance men were carefully selected to work with this team as highly skilled assistants. These men fell into two groups, one

group selected for a short term course of training, the other for a long term. Ambulance workers selected for the short term were trained over one month periods and were taught basic resuscitation techniques and some familiarity with the more sophisticated methods imparted so that these men could provide skilled assistance. Ambulance workers who did particularly well on the short course were selected for the long course. This period of training lasted for one year, and covered the indications for, and techniques of, intravenous fusion, endotracheal intubation and defibrillation of the heart. Men who completed both these courses achieved a high degree of understanding and skill.

The hospital training programme includes tutorials taken by medical and nursing staff. They are also given practical demonstrations of, and experience in, the technique of resuscitation and the immediate care provided in the Accident and Emergency Department, the Intensive Care and Coronary Care Unit, the Anaesthetic, Recovery and Operating rooms and selected wards.

It is the aim of this course to provide ambulance workers who are mature and experienced in judgement, as well as competent in technical skills, to become capable of providing a higher degree of medical support. On completion of their course, and also in the middle of the course, the ambulance workers will have written and oral examinations and an assessment of their practical skills. The successful candidates are awarded a certificate at the end of the course. After a period in the field the ambulance workers return to the hospital for another period of refresher training and

reassessment. This course will be of one week's duration twice a year or two weeks once a year.

The Medical Resuscitation Unit is based in the hospital. In this unit there will be one ambulance well equipped and two ambulance workers will be in attendance for eleven hours a day from Monday to Friday. One ambulance worker will be fully trained for unit work, the other will be undergoing training. The trained ambulance workers most often work on their own initiative, but they can be accompanied by a physician or anaesthetist or both if required. The procedure is for an emergency call to go to the Ambulance Controller, who decides whether to call the unit to a case and whether to ask for a doctor or nurse to accompany the vehicle. The Controller will then immediately contact the hospital to call the ambulance crew. Additional information can be conveyed to the crew over the ambulance radio when they are proceeding to their destination. The main cases dealt with relate to patients who become suddenly or seriously ill within a twenty mile radius of the hospital and for inter-hospital transport for very ill patients.

If we refer to Appendix G we can appreciate the importance of the work of the unit by examining the analysis of the responsible work undertaken by the ambulance workers who participate in it. We can appreciate the critical nature of the cases dealt with and the value of the service in saving the life of the patient. The Tables in Appendix G also illustrate the nature of the co-operation of the ambulance worker with the professionals attached to the MRU team.

When the ambulance workers returned to their normal duties

after their training in the unit, some of them felt frustrated and missed the facilities and the specialist equipment of the MRU vehicle. They were, however, provided with a special personal kit containing equipment for endotracheal intubation.

The work of this unit shows how ambulance workers provide a para-medical type service and relieve medical staff for other work, although there are some hospital workers and ambulance workers who believe that the MRU should be manned only by doctors.

It is evident that this pioneering venture shows how the potential of ambulance workers can be cultivated and maximised to help the patient. These ambulance workers received no additional payment for their work and responsibility and it is, of course, conceivable that the implication of such training can give rise to the emergence of a specialised group of ambulance workers with the status that goes with it.

One of the intrinsic rewards that these workers would clearly derive, is the satisfaction of being able to enlarge their helping role and to earn the respect and appreciation of the doctors and nurses who work with them and recognise their contribution. It also illustrates how the ambulance workers are brought closer into the hospital service as members of a team dedicated to patient care. The work of the unit also underlines the additional cost of a new role for some ambulance workers.

Porters

We might be inclined to classify hospital porters with domestics

until we realise that they, too, have some aspirations to change their occupational identity from a manual ancillary role to a minor para-medical professional role. This aspiration is reflected in the energies of the newly formed group, 'The Head Porters Association'.

The frustration of the Head Porter in the hospital service illustrates the role strain that can arise when the prescribed role is not congruent with the role concept of an occupational group. Head Porters, as well as their deputies and charge porters, do not enjoy staff status. Unlike their colleagues, the domestic superintendents, they are paid by the hour and do not enjoy the same fringe benefits as do the domestic superintendents. They resent, in particular, 'the humiliating position of having to work under them' in some hospitals. They realise that they are invited to departmental head meetings yet are not designated as managers. This feeling is expressed in the resolution passed at the Head Porters' Conference of 22nd October, 1975.

> Petition. The following Petition was signed by the members attending the Conference and despatched to the Trade Union Representatives of the four Trade Unions on the Ancillary Staffs Council of the Whitley Council for the National Health Service:
>
> We, the undersigned, being Head Porters and Deputy Head Porters employed in hospitals in the United Kingdom, and being in membership with a Trade Union represented on the Ancillary Staffs Council of the Whitley Council, wish it to be known by those representatives that the function we perform in the Hospital Service has sufficient managerial content to justify a transfer out of the Ancillary structure and into the Administrative and Clerical Staffs Council.
>
> It is our view that the present structure for Head Porters and their Deputies is so designed as to make it essential that excessive overtime and unsocial hours have to be worked in

> in order to secure a living wage, and that this is not in keeping with the status and dignity expected of the position.
>
> We furthermore feel that the retention of Head Porters within the Ancillary grades perpetuates a system which inevitably results in low standards of service and poor recruitment prospects.
>
> As some Health Authorities have already taken the initiative by regrading their senior portering staff into the Administrative structure, thus recognising the managerial nature of the position, it would be a short step for our representatives on the Staff Side to extend this principle to include other Head Porters, and Deputies, where they so desire it.
>
> The lowest appropriate trade in the Administrative structure to which a Head Porter would be appointed would be at General Administrative Assistant level, and that where the duties and responsibilities justified it, depending upon the type of hospital, number of beds and the number of staff controlled, this would be at Senior Administrative level.
>
> We find it necessary to make our views known in this way because as a group we cannot secure consensus representation at Union Branch level.

The Head Porters are conscious of the need to be trained and, although there is no national scheme, a number of authorities are exploring the possibilities of constructing a relevant scheme. A copy of a syllabus designed for the training of Head Porters is appended on page 350. It should also be noted that the Head Porters have, on their own initiative, introduced a diploma scheme to provide porters with a recognised qualification.

The Head Porters are concerned about the dilemma based on two aspects of their role. They want status and recognition for their specialised contribution to the hospital service yet they are aware that such status could result in a loss of earnings based on the hours of work. This ambiguity is expressed in the following statement, made at the conference.

> In order to secure improvements in our conditions, in order

> to secure an acceptable salary structure, and in order to secure equal status with other departmental heads - and I refer to status, not in its narrow sense, but in the sense that it is an essential part of a manager's equipment to enable him to function properly - it is necessary for us to be trained.
>
> We have suffered from long years of neglect and believe me, the authorities have a lot to answer for. They have frittered away vital human resources. There are Head Porters *and* Deputy Head Porters with all the ingredients necessary for successful management who have been thrown into terrifying management situations without any kind of training to fit them to cope with those situations. But having said that, I am bound to say that we, ourselves, cannot escape some of the responsibility for this sorry state of affairs. We have failed to educate ourselves. We have failed to take advantage of training opportunities when they have been presented to us. And even now when we have successfully negotiated training schemes in the South West, the North West, and in Scotland - I wonder whether we have left it too late.
>
> Throughout the year we have made representations to the staff side of the Ancillary Staffs' Council with a view to enabling those Head Porters who desired it an opportunity to transfer to the administrative and clerical structure. But here again, too many of us have fallen for the bait of overtime and deluded into thinking that we are sitting on a goldmine. But this is an illusion and I can tell you that there are many people in the Health Service with less demanding and less responsible jobs than ours who are laughing at us because they are earning far more than we are without the necessity to work overtime.

Domestic supervisors

The domestic supervisors have also shown some interest in improving their occupational status. In 1975 a group of domestic superintendents and supervisors formed the Association of Domestic Management. The objectives of the association are outlined in its Memorandum of Association. One of the key objectives is presented in Section 3(i) of the memorandum:

> to do all within its power to supply, maintain and encourage an efficient domestic service to support the medical, nursing and allied services throughout the National Health Service in their work for the healing and comfort of the sick, to provide and maintain a national code of practice to complement professional

> and occupational training, to take all such action as may be deemed necessary or expedient to improve standards of training amongst domestic staff within the National Health Service, Department of Health and Social Security and comparable Government Service and Local Authority Service and to promote cooperation by the interchange of knowledge.

It is interesting to note the strong identification with the caring professions and all concerned with helping the sick, which is enshrined in the objective referred to. The domestics in the NHS who are in the forefront of this association are clearly stating the worth and value of their contribution to patient care. Whilst the rank and file domestics are not eligible for membership of the association with membership confined to those in managerial and supervisory positions, the forming of such a group can be seen as an ideological plea for domestics and housekeepers to obtain some degree of status and recognition in hospital organisations where professional status is highly valued.

There is evidence that ancillaries in most of the groups expressed an interest in improving their occupational status and I will now consider the interest of these groups in what may be described as the more tangible extrinsic rewards.

Economic aspirations

In this section of the chapter I will consider the economic rewards that hospital ancillaries obtain for their services. I will also consider the way in which they have endeavoured to achieve an improvement in their living standards, particularly through the use of industrial sanctions. The discussion in this chapter should provide some indication of the extent to which personal service ancillaries have been appreciated by the general public and have the type of support envisaged by Halmos.

Wages

The wage rates and earnings of each of the main ancillary occupations will be analysed and they will be compared with earnings of nurses, one of the main occupational groups in hospitals. We also need to compare the wages of hospital ancillaries with those earned by groups outside the service. Of particular interest will be the wages of workers in the manufacturing industry, workers in all industries and the wages of such traditional low income groups as those workers whose wage rates are determined by wage councils.

In 1972, 94,000 hospital ancillaries withdrew their labour for one day to protest against the Government pay policy. In 1973, over 285,000 days were lost due to a strike by NUPE and COSHE over a rejection of the Government's pay policy of £1 + 4%. This strike affected the whole of the hospital service with 55,000 ancillaries withdrawing their labour for 21 days. In the same year 400 ambulance workers lost 5,000 working days over a dispute concerning their demand to restore £2 a week which they lost as a result of their wage agreement with the local authorities.

In 1974, over 1,000 ambulance workers withdrew their services to protest against measures taken by their administration to restrict their earnings in response to ambulance workers refusing to deal with all but emergency calls in pursuance of a national pay claim. Hospital technicians were also involved in a dispute over a pay claim. The cost of these two strikes is illustrated in Table 21.

TABLE 20

INDUSTRIAL DISPUTES IN THE HEALTH SERVICE
1974

Cause	Workers involved in dispute		Working days lost
Pay claim	Ambulance workers	1,000	5,000
Pay claim	Hospital technicians	1,170	13,600
Other		2,530	4,778
	TOTAL	4,700	23,378

Source: D.E.P. Gazette, June 1975

We can see from the above statistics that the major cause of industrial unrest was concerned with wage claims.

In order to understand why ancillary workers in the hospital service were willing to engage in industrial action and disrupt the normal activities of the hospital, we need to examine their wage rates and weekly earnings. We also need to know how these rates and earnings compare with the rates and earnings of other occupational groups.

Hourly rates and weekly earnings

In Table 22 we can note the hourly rates of pay, the weekly average earnings and the average hours worked for the weekly earnings, these averages based on the arithmetic mean for these variables. I will present this data for all male manual workers, and non manual male workers. I will also include the relevant data for some groups of ancillaries.

TABLE 21

HOURLY RATES, WEEKLY EARNINGS AND HOURS WORKED FOR MALE WORKERS IN 1974

	Hourly rate	Weekly earnings	Average weekly hours	Overtime
All manual	91.1p	£43.6	38.8	6.5
All non-manual	137.9p	£54.4	46.5	1.4
Porters	70p	£32.2	46	6

Source: New Earnings Survey, April 1974

It is evident from the above table that non manual workers were in a more favourable position than manual workers in respect of hourly rates, weekly earnings and the amount of overtime worked for the weekly wages. It is also evident that the porters whose earnings were similar to theatre assistants and other ancillaries, were in a less favourable position than non manual and manual males. The porters' earnings as a percentage of the male manual workers' earnings were 77%.

It has been well established that female manuals and non manuals earn considerably less than their male counterparts but we also find differences between the manual females and the non manual female workers. These differences can be seen in Table 22.

It will also be interesting to consider the extent to which domestics and other hospital workers, such as the trained nurses (SRNs and SENs) and auxiliary nurses vary in respect of their earnings from the manual and non manual average.

TABLE 22

HOURLY RATES, WEEKLY EARNINGS AND HOURS WORKED FOR FEMALE WORKERS IN 1974

	Hourly rates	Weekly earnings	Average Weekly hrs.	Hours overtime
All manual	58.7p	£23.6	39.8	1.2
All non manual	76.7p	£28.1	36.8	0.4
Domestics		£21.1	39.5	0.4
Nurses	65.3p	£26.0	39	0.4
Auxiliary nurses	54p	£21.0	39	0.4

It is evident from Table 22 that domestics compared favourably with the manual workers in terms of their hourly rates and their weekly earnings. We can also note that they received a rate only marginally comparable to the porters and this can be attributed to the equal pay policy of the NHS. It is, however, of some significance that they earned less than porters because they worked less overtime, and they were on a 'lowest' pay grade for all ancillaries.

It is also evident that the trained nurses had a higher hourly rate and higher weekly earnings than female manual workers, but they had a lower hourly rate and lower weekly earnings than the non manual female workers. It is also evident that the differentials in respect of hourly rates and earnings of the trained nurses and the auxiliary nurses and domestics did not reflect the responsibility and skills of these groups.

If we direct our attention to the position in 1981, we can see that there had been no significant improvement for hospital

porters or domestics as we can see from Table 24 below.

TABLE 23

HOURLY RATES, WEEKLY EARNINGS AND HOURS WORKED FOR MALE AND FEMALE WORKERS IN 1981

MALE	Hourly rates	Weekly earnings	Weekly hours	Overtime
All manuals	269p	£121.9	44.2	4.5
Non manuals	419p	£163.1	38.4	1.3
Porters	205p	£ 97.1	45.8	5.8
Ambulance workers	275.7p	£130.3	45.9	5.9
FEMALES				
All manuals	188.2p	£ 74.5	39.4	1.0
Non manuals	259.2p	£ 96.7	36.5	0.4
Domestics	205.2p	£ 81.5	39.5	0.4
Nurses	1249.5p	£ 93.9	37.5	0.2
Auxiliary nurses	212.9p	£ 79.8	37.5	0.6

Source: New Earnings Survey, 1981

It is evident that in terms of hourly earnings, exclusive of overtime payment, not only did male ancillaries (unlike the females) compare unfavourably with other manual workers and non manuals in 1974 and 1980, but that their relative position had deteriorated.

The differential between males and females in manual and non manual occupations has always been very wide in that females have been more vulnerable than males to wage exploitation. They might also have a lower degree of instrumental orientation to work, as noted by Beynon and Blackburn[21], are usually less involved in trade union activities than males, and are more prominent in the low skilled occupations than males. But in the case of the male

and female ancillaries, these differences are not so pronounced. Ancillaries, such as porters and theatre assistants in predominantly male occupations, have only been involved in trade union activities within the last decade. Male ancillaries do not possess highly marketable skills outside the NHS. In view of the fact that many porters have entered portering in their 40s, and have tended to look for a job that is not physically demanding, they might well be expressing a lower degree of instrumental orientation than other manuals and, in this respect, have similar work expectations to the domestics and other female ancillaries. Indeed, I have noted this point in Chapter Three, where I examined the work expectations of ancillaries and found only a small percentage referring to wages as an important consideration.

Shift premium payments

There is also another factor which should be considered and this relates to the extent to which domestics probably work more unsocial hours than other females. A substantial part of their working week is concerned with cleaning hospitals in the evenings and on Saturdays and Sundays, when nurses and medicals are less involved with their patients.

This inference might also be derived from the data published in the New Earnings Survey of 1981, which demonstrates that 19.7% of the domestics' earnings is attributable to shift premium payment, a much higher proportion than that of the female manuals and non manuals and, indeed, of other male ancillaries such as the

ambulance workers and porters. This is evident if we refer to Table 25, where we can compare the earnings of those workers with payments based on shift premiums.

TABLE 24

EARNINGS OF EMPLOYEES WHO RECEIVED SHIFT PREMIUM PAYMENTS IN 1981

MALES	Average earnings	Overtime payment	P.B.R.	Shift premiums
Ambulance workers	£132.8	£20.8	£8.4	£16.4
Porters	£102.5	£16	£6.9	£16.1
Manuals	£140.7	£20.6	£10	£17
Non manuals	£161.8	£17.9	£3.2	£18.2
FEMALES				
Domestics	£ 88.9	£ 2.2	£1.4	£19.3
Manuals	£ 90.5	£ 5.0	£4.2	£14
Non manuals	£ 99.2	£ 1.9	£0.4	£11.7

We can see from Table 25 that male workers tend to depend more upon overtime and shift premium payments than females. It is also interesting to note that the domestics tended to depend less upon overtime than other manual females but they received a larger proportion of their earnings from shift premium payments than other female workers. We should note that, whilst the overall average earnings of domestics were higher than that for other female manuals, they were marginally worse off than those female workers who received shift premium payments.

To some extent the more favoured position of the domestics is due to the equal pay policy in the NHS, but a more plausible

explanation is that the domestics tend to work more unsocial hours than porters and other ancillaries, because a great deal of domestic work is carried out over the weekends when hospital activities tend to be less demanding than is the case during the week when most of the operations and patient treatment is undertaken.

As a result of working on evenings, Saturdays with payment at time and a half, and Sundays at double time, this tends to boost the earnings of domestics and places them in a more favourable position than other female manual workers. This is reflected in the shift premium element of their pay, referred to in Table 24.

The proportion of weekly earnings attributed to shift premiums can vary between ancillary occupational groups. There is some evidence that theatre assistants tend to be more involved in shift work and overtime work than porters. The fact that the theatre assistants can boost their earnings in this way is one of the reasons why some theatre nurses feel strongly about some assistants earning more than nurses. This was certainly an issue in the Dulwich and Greenwich disputes between theatre nurses and assistants in 1977. The advantage in respect of earnings is one of the reasons referred to by those theatre assistants who would prefer to remain as ancillary workers rather than be paid on a similar basis to nurses. A preference for wages rather than status.

The earnings of theatre assistants are calculated on the same basis as porters. Whilst theatre assistants, like porters, can

be considered to be low paid workers, their earnings are sometimes resented by nurses. The basic pay of the theatre assistant at the mid point of the scale in 1981 was £68.73, the assistant could also earn a bonus of 25% on the basic rate which would give the assistant £17.81. The assistant could also earn an additional £4 for alternating on a shift and be paid overtime and time-and-a-half for Saturday work and double time for Sundays. An assistant who worked four hours on Saturday for £12.28 would earn a gross weekly wage of £102. When we consider that the weekly gross pay for nurses in 1981 was £79.70, we can appreciate their concern about their relative positions.* One of the reasons for this differential is that nurses are not usually paid overtime, nor do they qualify for shift premiums, but have time off in lieu of inconvenient hours worked.

The position of ancillaries in the earnings league

If we consider another comparative view of the earnings of hospital ancillaries, we can note the percentages of the manual employees who earned less than the average earnings of these groups. This data is presented Table 25.

TABLE 25

THE PERCENTAGE OF LOW INCOME EARNERS IN 1974 AND 1981: MALE AND FEMALE

MEDIAN AVERAGE WAGE			
EARNINGS LESS THAN £40 IN 1974		EARNINGS LESS THAN £120 IN 1981	
	£	MALES	£
Porters	86.3%	Porters	84.2%
Manuals	43.7%	Manuals	56.7%
		FEMALES	
Domestics	(information not available)	Domestics	65.6%
Manuals	84.6%	Manuals	79.7%

* Registered and enrolled nurses and midwives

If we look at the extent to which hospital porters improved their position between 1974 and 1981 in respect of their hourly rates, we find that, in 1974, the rate was 72.9p an hour and, in 1981, it was 205p an hour. The corresponding rates for male manual workers were 87.1p for 1974 and 269p for 1981. The porters' percentage of the male manual rate for 1974 was 83.7% and, in 1981, it dropped to 76%.

If we now consider the third aspect of the ancillary workers' position which relates to the ranking of weekly earnings, we find that, on the basis of the data from the New Earnings Survey of 1981, the porters were placed in the 86th position out of 102 occupations. This clearly indicates that porters are low income earners even after considering the overtime hours that they work.

I have established that male ancillaries are, in general, lower paid than other male manual workers but the differential between the lower paid ancillaries and other male manual workers is greater than the differential between the domestics and other female manuals. The differential between the females tends, in fact, to move in the other direction with domestics tending to earn more than other female manual workers, except in the case of other shift premium female manual workers.

I have established that, on the four yardsticks for measuring the earnings of hospital ancillaries, hospital porters and other ancillaries such as theatre assistants, were worse off than other manual workers. It should, however, be noted that ambulance workers were not in such an unfavourable position and this might

well be attributed to the industrial militancy that they have demonstrated during the last decade.

Industrial disputes

The first industrial dispute in the NHS which attracted the interest and concern of the public occurred in 1973. The refusal of hospital ancillaries to accept the Government offer of £1 - 4%, and their counter claim, was the cause of a dispute which can be described as a major influence in the hospital sub-culture. It was the beginning of a new chapter in the history of the health service. It was the first dispute of magnitude and served as the forerunner of other disputes involving nurses, consultants, junior doctors and medical technicians. There had been occasional disputes over wages in the hospital service before. There was a 'stay-in' strike in Cheadle Royal Asylum in Cheshire in 1920. This lasted for a day but a satisfactory solution was reached. In September 1921, members of the branch of the National Union of Asylum Workers at Bracebridge (Lincoln) Asylum withdrew their labour for a day in protest over a wage reduction.[22]

In April 1922, the officials at Radcliffe on Trent County Hospital of Notts reduced the wages of its workforce and increased their working hours. Male and female nurses withdrew their labour for a period of four days. As a result of this dispute many hospital workers lost their jobs and considerable bitterness and ill-will prevailed for some time amongst the workforce and between hospital workers and officials.

There is considerable evidence to indicate how the Mental Hospital and Institutional Workers' Union were involved in negotiations to improve their conditions of service. It is also significant that members of this union, throughout its turbulent history, were conscious of their obligation to their patients. This concern was expressed in the instructions issued by the union in the Radcliffe dispute which provided a code of behaviour to protect the interests of the patients. These instructions were:

1. The patients' welfare and safety must always be the first consideration.

2. All orders (other than medical orders) received from the Mental Hospital official must be disregarded. Purely medical orders must be obeyed. In other cases the instructions of the Union officials are paramount.

3. Patients will be dressed, washed, fed and safeguarded *as usual*.

4. There must be no personal violence offered to, nor any interference with, officials of the hospital or non-unionists: nor must the patients be incited to commit acts of violence.

In the early 1970s, there was considerable unrest in the hospital service about the rewards for hospital workers. This was particularly true of the ancillary workers, nurses and medical technicians. If we focus our attention upon the wages paid to ancillaries, we can appreciate why they considered themselves to be lowly paid and why such dissatisfaction about their wages engendered a major dispute which introduced a new value into the hospital

sub-culture, a value which was in conflict with its central value - care of the patient.

If we examine the wage rates and weekly earnings of hospital ancillary workers before they engaged in industrial action, we find that they are well down in the earnings league. The median average wage was certainly lower than the median average for the semi-skilled male workers in other industries and well below the median average calculated for male workers.

Sanctions

My analysis of the wages and earnings of hospital ancillaries demonstrates that there has been no significant improvement in their position in spite of the fact that they have pursued a militant policy with the use of industrial sanctions. If we look at Table 26, we can see the extent to which strikes have increased in the last decade.

TABLE 26

INDUSTRIAL DISPUTES STATISTICS FOR THE PERIOD PRECEDING AND FOLLOWING THE YEARS 1972 AND 1973

	NO OF NHS STAFF	NO OF STOPPAGES	NO OF STAFF INVOLVED	NO OF DAYS LOST	NO OF DAYS LOST PER 1000 WORKERS
1966/71	778114	3.7	1226.3	3196.7	4.5
1974/77	922578	18.25	4370	16550	18.3

Source: compiled from statistics provided by Health Departments and the Department of Employment*

* See Table A10 for more detailed information on strike statistics

Ancillary workers and other hospital workers have increasingly resorted to strikes to improve their incomes and conditions of service. Writing about the problem of industrial strikes in the Hospital and Health Service Review in 1974 , the editor expressed concern about the increasing use of industrial sanctions and in particular the increasing involvement of non manual workers:

> Union leaders used to inconveniencing the public as a way of pursuing their members' aims see no reason why the health service should be exempt from this tactic. The caring profession might be expected to think differently and after all, the majority of nurses did not strike, but it is clear that the general attitude among professionals and middle class workers may outweigh any traditions or feelings of any special obligation to the patient. [23]

It is interesting to note that this editorial is concerned about the changing work culture of hospitals and the increasing militancy of professional workers. Another article in the same journal in May 1975 by Sugden , a hospital administrator, is also concerned about the changes in the hospital work culture as a result of industrial sanctions,

> So far as the *health* service is concerned we have seen health service workers who traditionally did not strike resorting to this weapon. The pay bed row has shown that political issues, even in this service, can be pressed through industrial action. Although negotiations take place centrally much of the pressure has been applied locally and has to be faced by various administrators in conditions where the *ground rules* and tactics were not clear to many of the participants.[24]

The danger of neglecting the patient because of industrial action by hospital workers is the cruel dilemma that confronts hospital workers who contemplate or engage in such action. Hospital workers are very conscious of the harm that can be inflicted upon

the patient and one way of coping with the conflict between concern for the patient and the value they place on industrial sanctions is to ensure that emergency cover is arranged, so that critical patient cases can be dealt with. There are, however, a number of administrators and senior medical men who are not satisfied that emergency cover is adequate and will not guarantee loss of life. A typical view which reflects this concern was expressed by a hospital administrator writing in the Hospital and Health Service Review of February, 1974.

> Not to harm the patient. At first sight it seems odd that groups of health service staff taking 'industrial action' should be able to claim that they are not harming the patient, yet on the whole that does seem to be the case. Whilst one should treat the claim with reserve, most accusations to the contrary made in the heat of the moment about specific cases have proved at least doubtful.[25]

It would be carrying rhetoric a bit too far to suggest that industrial action will benefit the patient and it is quite untrue to say that action is taken for his benefit. The patient is the *raison d'etre* of all health service staff and the point of reference for the organisation of working activities, but for professions and groups of staff, as distinct from some individuals, it is quite untrue to say that the patient comes first. This has always been obvious and need shock only those who have misunderstood the situation.

It is possible that a regard for the patient's interest has restrained the staff's pursuit of its own interests and it has certainly affected the form that the pursuit has taken. A very real regard for the patient, which nearly all staff feel, an awareness

of public opinion and, perhaps, a sense that one does not hit one's *raison d'etre*, make it highly desirable to do nothing that can be construed as hurting the patient. Professional staff who have trained for a lifetime's career in the health service may continue to accept this constraint, but it is difficult for staff who, but for little more than an accident, might have been working in hotels or factories or driving a 'bus. The health service does not give them material advantages to compensate for not using the strike weapon which would be regarded as legitimate for similar staff in other types of employment. In health service terms, a complete strike by ambulance staff is indefensible, yet to condemn it in principle is not easy unless one is prepared to condemn the right to strike in general. Fortunately, most industrial action in the health service has been of the sort which it could fairly be said did not hurt the patient - even though this restraint weakens the coercive effect of a strike.

The claim that the patient is not hurt has been heard in another context recently. The Department of Health and Social Security stressed in December, that the cuts in health service expenditure announced by the Chancellor of the Exchequer would not mean that the patients would suffer. And this, too, on the face of it is a reasonable claim. After all, it is not the first time the service has lived through such cuts.

What harms the patient is a matter of degree. To receive only a cold meal, or not to be taken to a day hospital or a physiotherapy clinic in a sense causes harm and in a few years' time a patient

may be harmed by the non-existence of a new hospital which would have been there but for the cuts in the building programme. The concept of harm is elastic.

An important insight into the effect of industrial militancy upon the hospital service was expressed by Dr. Roger Dyson of the University of Keele, who wrote a report outlining how ancillary staff industrial action in 1973 had affected hospitals in the Leeds area. In this report, he urged that more emphasis should be placed on the different needs of different hospitals during industrial disputes, such as geriatric hospitals and acute hospitals. Geriatric hospitals would be forced to reduce standards of patient care in the event of a strike, but acute hospitals might restrict admissions. The writer stressed the necessity of the unions and hospital management working out an agreement about the type and form of emergency cover that should be provided by the hospital service during a dispute. This agreement would lay down acceptable norms of industrial militancy in the hospital situation and establish recognised guidelines for providing emergency cover for patients.[26]

This view on emergency cover outlined by Dr. Dyson was not accepted by the editor of *The Hospital and Health Service Review.* Writing in the editorial of this Review in January, 1975, about an agreement on emergency ocver, he strongly dismissed the notion that patients cannot be harmed by strikes if emergency cover is arranged.

> The strikes that have affected the health service subsequently have increasingly revealed the implausibility of the belief that health service staff can strike effectively, without harming the patient, and it may be that in future strikes,

staff will take the more honest but more disagreeable line that they are trying to achieve their ends by inconveniencing or harming patients.

Criticism against industrial militancy is also levelled against hospital workers by the press. An editorial in *The Guardian*, 13th November 1973, was very critical about the strike of ambulance workers at that time, and is typical of the type of pressure that can be brought to bear on hospital workers engaged in such action.

> A Matter of Life and Death. There is no clear line dividing the small category of workers who have no right to strike from the large majority who do enjoy the right. But one group of workers which indisputably belongs to the first category is ambulancemen. No pay dispute is worth letting someone die. Any ambulance strike must make this a possibility. It is difficult to point to a more irresponsible strike than yesterday's by London ambulancemen. It was not the country's first ambulance strike. That occurred earlier in the month at Burnley, but lasted only two hours. A second strike in Durham lasted a week, but the local council was given sufficient time to organise volunteer drivers. London ambulancemen did not just come out on strike, but like Ipswich last week only gave notice of their strike at the last minute, leaving the local authority no time to arrange volunteers. Do the ambulancemen really believe that their cause is so just that they can risk men dying for it?
>
> Many strikes indirectly threaten lives. Both the electricity supply workers and the gasmen have been accused in the past of causing old people to die from lack of heat by their industrial actions. But it was partly because of the danger of death - in hospitals as well as by hypothermia - that the electricity supply workers have not gone on strike, but used go-slows and work-to-rules. A young police constable lay seriously injured in a London street for almost half an hour yesterday. He was finally taken to hospital, suffering from serious head injuries, by a local council ambulance carrying elderly people which just happened to be passing at the time. None of the 1,900 ambulancemen who were on strike yesterday would have failed to come to the aid of the policeman if they had been at the scene. That they did not know about his particular plight does not lessen their responsibility for the delay in hospital care. Several hours after the incident the policeman was still unconscious in hospital.

> an emergency service was being run by 150 senior officers yesterday. They were able to answer most emergency calls within eleven minutes compared to the normal eight. But delays in individual cases were inevitable. A group of 150 men cannot do the work of 1900, even if they are only answering emergency and accident calls. The new pay offer for local authority workers announced yesterday may well leave the ambulancemen dissatisfied. That does not mean that they will be justified at their national delegate meeting tomorrow in calling for further lightning strikes. With an average wage of £38 a week the ambulancemen are by no means badly done by. A proposed efficiency scheme has been turned down, but it is still open to the service to produce another scheme. The forthcoming mergers - from 120 services to 40 - due in April should offer plenty of scope. The ambulancemen have no right to risk other people's lives to get more. It is time the leadership of the four unions involved asserted itself. It has spoken with too muzzled a voice so far.

Ambulance workers are concerned about the nature of the criticism levelled against them, particularly the suggestion that they are indifferent to the needs of the patients. A leading article in *Ambulance Journal* of March 1979 expressed this concern.

> Virtually without exception, the national daily headlines screamed out the chilling statement attributed to Bill Dunn a COSHE shop steward and spokesman for London's 2,300 ambulancemen. It heralded a 24 hour total strike which occurred the following Monday, January 22. It was part of the public service unions' "day of action" against the Government's pay policy.
>
> The London ambulance service normally operates 145 emergency abulances during the day time which is reduced to about 80 at night. Approximately 1,500 calls are received each day. Contingency plans involving the use of troops, police, St. John and Red Cross volunteers, with vehicles based at police stations throughout the metropolis were brought into operation.
>
> Ambulancemen in Birmingham, Cardiff and Merseyside took similar action. London ambulancement subsequently operated an overtime ban and refused to use their radios. This was reported to be seriously effecting emergency services.
>
> By the second week in February most services in the country were operating an "emergencies" only service conforming to the guidelines drawn up by the union's National Coordinating Committee. This

comprised 999 calls, maternity and urgent admissions, radiotherapy and renal dialysis patients and terminal discharges. This action was thought not only to put some patients at risk but to create a serious congestion - particularly at district general hospitals - where patients normally discharged by ambulances were occupying beds required for incoming emergency cases.

As an alternative to suspension without pay, most ambulance authorities were ensuring that those personnel normally not employed on emergency duties - mainly on days - were used to fill absences on emergency shifts and/or were engaged in local training.

At a national meeting on February 20, ambulance stewards voted 2 - 1 against an all-out strike and decided to await the outcome of further negotiations the following Thursday.

However, striking ambulancemen took unofficial action and that night in London only 32 ambulances, including just six south of the Thames were without emergency cover and there was an all-out strike in Aberdeen.

Army ambulance units, police and voluntary aid societies were said to be standing by throughout the country.

It is understood that the latest offer to ambulancement is an immediate 9% backdated to November and a comparability study paying 50% of any additional recommended increase in August followed by the remainder in April next year.

The widespread industrial action has drawn editorial comment from all shades of political opinions.

The Sunday Mirror referring to a recent Gallup poll on the standing of trade unions said, "Well done brothers, you couldn't have done more harm to your cause if you were your own worst enemies ..."

Writing in the Sunday Express George Gardiner MP for Reigate said "Would you have thought even a couple of years ago that anyone would slash the tyres of ambulances to block the main service entrance to a hospital in which people were seriously ill". Even in armed warfare the sign of the Red Cross was respected that wounded might be saved". There is little sign of such compassion in the war of attrition now being waged in our hospital and ambulance stations".

It is quite evident that industrial action in the health

service does interfere with the care of the patient, and it is difficult to predict that no patient will die as the result of such action, even if emergency situations are covered.

We know that the ancillary strike in 1973 was the first major confrontation between the hospital authorities and some of its employees. Since that time nurses have been on strike, and junior doctors and hospital consultants have worked to rule. The nurses and doctors were concerned with improving their income and conditions of service. The hospital consultants were fighting for their traditional right to be allowed to treat private patients in the health service.

It could be argued that the ancillaries were the first group of hospital workers to initiate strike action on a major scale, and such action introduced a new element into the hospital sub-culture. This new element of withdrawal of labour is precariously balanced with the commitment to care for the patient. Are we now witnessing a change in the hospital sub-culture where willingness to risk the care of the patient is being assimilated into the role of the hospital employees, be they porters or consultants?

Another implication in this new situation is that there are now emerging inter-group differences. This is illustrated by the trade unions representing the ancillary workers, threatening to take counter action against hospital consultants who introduce sanctions in their bid to retain their traditional privileges. This action by the ancillary workers has a political motive but it is of considerable significance that the traditional right of the senior

professionals, whose leadership role has been a main determinant of hospital values, is now being questioned and opposed by militant action.

Because of the importance of the ancillary workers' attitude to strikes, or other forms of industrial action, I sought to understand the degree to which ancillaries were willing to use industrial sanctions in the hospital situation. Attitudes towards industrial sanctions were explored through the questionnaire and also by individual discussions with ancillaries, and with groups of these workers. The responses to four questions presented to the sample of ancillary are presented in Table 27.

TABLE 27

THE ATTITUDES OF ANCILLARY WORKERS IN THE HOSPITALS TO INDUSTRIAL SANCTIONS

ATTITUDES TOWARDS INDUSTRIAL SANCTIONS	OCCUPATIONAL GROUPS				
	AMBULANCE (n = 26)	THEATRE (n = 45)	PORTERS (n = 39)	DOMESTICS (n = 50)	CRAFTSMEN (n = 21)
	PERCENTAGING TO COLUMN TOTALS AS A BASE				
	%	%	%	%	%
Strikes should never be used	36	20	32	32	17
Strikes sometimes justified	50	50	47	48	61
Other sanctions appropriate	7	26	10	18	17
No difference to strikes elsewhere	7	4	11	2	5
ANCILLARIES RESPONDING (0 100%)	100	100	100	100	100
	26	42	38	46	19

$X^2 = 7.4$ C = 0.20 Not significant at 0.05 for d f 8*

(* adjustment to cells)

It is evident from the responses of the ancillaries above that only a very small minority of ancillaries in each of the occupational groups were of the opinion that strike action in the hospital service did not differ from such action in other organisations. A substantial percentage believed that there should be no strike action in hospitals, but the majority of ancillaries were in favour of moderate sanctions, or expressed a reluctance to strike. The views on strike action suggest that concern for patient care is a norm that is accepted by theatre assistants who work with professionals and who have been trained in the professional work culture and by maintenance craftsmen who have been socialised in industrial organisations.

Ancillaries are aware that industrial action in the hospital can harm the patients; some of the comments expressed to me illustrate this concern.

Ambulance worker

> Of course withdrawing our labour can affect some patients but we have to look after the patients where possible, particularly emergency cases.

Theatre assistant

> I refused to go on strike a couple of years ago and I left the union as a result of this. I don't want to be involved.

Domestic

> We don't like being involved in strikes but are taken advantage of because strikes can harm patients.

Domestic

Striking in hospital is not easy. It creates all sorts of problems.

Domestic

When I have been on strike I feel a bit concerned about the effect it can have upon some of the patients.

These comments reflect the anxieties that ancillary workers have about striking and illustrate one of the problems that they are compelled to cope with to improve their wages and general status. Industrial sanctions in the hospital service can have damaging consequences in respect of the care needed for patients. There is also the problem of defining what constitutes emergency coverage. This can be one of the most controversial issues that emerge in disputes. Sometimes efforts to resolve this problem involve consultants negotiating with porters or theatre assistants about what operations should be allowed during an industrial dispute.

Strikes and industrial sanctions represent new elements in the sub-cultures of hospitals and other health units. The views of Seccor and Backman[27] are of interest here. "Individuals in occupations such as medical social work and the Ministry and the teaching profession are exposed to a number of ideological elements emphasising service to humanity. Yes - at the same time they share with other members of society the ideals of materialistic success".

McArthy[28] has recommended a number of changes in the industrial relations system in the hospital service. He stressed the need for an objective look at the whole of the joint consultative system

within the context of the current interest in industrial democracy. The negotiating structure and the disputes procedure also need reviewing. He also stressed the need to provide arbitration procedures where a dispute can be referred to either by the trades unions or by management, and that any decisions taken should become binding for both groups. The dilemma which faces the government, according to McArthy[29] is related to the problem of satisfying public expectations and also fulfilling its responsibility as an employer, has considerable implications for ancillary workers. He recognised that hospital employees should be treated fairly and be rewarded for their important work and recommended that the pay of health workers should be based upon the findings of a pay research unit such as the Civil Service Pay Research Unit. Information from this unit should ensure a reliable basis for a fair method of payment for hospital workers.

We can see from the comments of the ancillary workers that the use of strike sanction is a source of role conflict for many hospital workers. The type of anxiety provoked by the possibility of being involved in strikes which might harm the patients can be exploited by governments who recognise that most of the occupational groups in the hospital service lack effective bargaining strength. There is surely a special need for taking some of the heat out of the conflict between hospital managers and non-managerial employees who have to cope with the consequences of those decisions made by the Department of Health and Social Security (often pursuing some form of incomes policy). There should be a more equitable basis for rewarding hospital workers who can only hurt the employer by

hurting the patients. It is evident that, in the case of the majority of hospital male ancillaries, they have less bargaining power than most male manual workers. The hospital service needs a committed workforce but, can vocational commitment be nurtured in the framework of a service torn by conflict? What must be established is that the ancillary makes an important contribution to the care of the patient and the effective running of the hospital service. There are some signs that their earnings position has deteriorated over the years. It should not, and this is surely a cause for concern.

We can also do more to raise the earning power of ancillary workers by opening up the avenue for training them for higher grade work. To some extent, these opportunities exist for ambulance workers and for the theatre assistants. Very little has been done for porters and domestics and this needs to be given serious consideration to raise their status and economic rewards.

Dyson[30], in his study of the consequence of the ancillaries' strike of 1973 in Yorkshire hospitals, has urged management and trade unions to work towards a measure of agreement about what constitutes emergency coverage in the hospital. The lack of agreement on this between these groups caused considerable confusion. Different types of hospitals have different problems and different needs, and the failure to relate emergency coverage to these needs can be harmful to the patients. Unless, of course, the participants wish to ignore the need for some rules and guidelines.

It is not my intention to explore the intricacies of the

industrial relations system, although a detailed study is desperately needed. I hope, however, to show that ancillary workers who are compelled to resort to strike action are vulnerable to role strain because they are torn between the desire to be loyal to the patient and their concern that their earnings and status are not allowed to fall below what they consider to be a reasonable position.

I have described the pattern of earnings of ancillary workers and I compared them with the earnings of other hospital workers and workers in industrial occupations. I will now consider the sociolotical implications of these findings.

Navarro[31] argued that the occupational structure of the hospital workforce reflected the class structure of capitalist societies. When we consider the social background of particular occupational groups we find that Navarro has a point. Doctors in the U.S.A. and in the U.K. have been predominantly drawn from middle class homes (Waitzkin and Waterman[32]; Titmuss[33]). Para-medical workers and SRNs have been drawn from middle class skilled workers' homes*.[34] It is also evident from the N.B.P.I. Report of 1971 that the vast majority of ancillaries are from predominantly semi-skilled or unskilled workers backgrounds.[35]

It might be conceded that, in terms of the social background of the workforce, social differences exist. But the point about the relationship between social background and occupational status is that the more favourable the background, the better the opportunities

* The Briggs Report, 1973

for the secure and well-paid jobs that have some degree of status. If we compare the earnings of the para-medicals state registered nurses with those of the ancillaries, we find that they are only marginally better paid. They are also only marginally better off in terms of security and in terms and conditions of service relating to holidays and pensions. The sharpest difference might well be in the degree of status which is related to the respective occupations.

We find that the most pronounced difference in respect of earnings are those which exist between consultants and other hospital workers. It is possible that the gap that exists between the consultants and the other occupational groups presents a situation that reflects the sexist divisions in the hospital workforce. Consultants have been, in the main, male workers and the nurses, and to some extent the para-medicals, have been predominantly females. When we look at the ancillary workforce, we find that the domestics are almost exclusively female workers although they represent the largest single occupational group of ancillaries and nurses represent the largest of the professional groups.

The predominance of women in the lower paid occupations is a factor worthy of particular consideration. Salaman[36] argued that the workforces of capitalist societies comprise two broad categories of labour. The first category is made up of skilled, clerical, managerial and professional workers and they are defined as a 'primary labour market'. The people in the primary market have marketable skills. The second category is defined as the 'secondary labour market' and comprises women, non-whites and others

who find it difficult to obtain a job because they have limited marketable skilles.

Now, primary workers have certain advantages when compared with the secondary workers in terms of negotiating jobs. This is particularly the case when we consider the structure of the occupations that predominate in the unemployed sections in this country and in the U.S.A. Whilst nurses who are State Registered or Enrolled have marketable skills, the employer has always been in a favoured position when arranging the terms of employment of nurses. This factor, coupled with the traditional lack of militancy among nurses, and their strong commitment to patient care, might well explain the reason why nurses have not been in a strong bargaining position.

The influence of occupational groups and their concern about improving or maintaining their economic position and social status, tends to some extent to undermine the view presented by Halmos about professionals being obliged to raise the status and standards of their subordinate groups. There is no strong evidence that the consultants have improved the position of nurses through consistent support for their genuine case, neither have they been too favourably disposed to support the junior doctors who have complained about the long hours they had to endure and their relatively low earnings, to provide the consultants with support and overall cover for medical care.

It might well be the case that the high proportion of females in nursing, para-medical and ancillary occupations, provides the

administrators of the hospital service with a malleable and vulnerable workforce. It has been well-established that many female workers move in and out of work due to the changes in their family status and it might well be the case that women workers in hospitals share some of the characteristics of women workers in industrial situations. One example is that presented by Beynon and Blackburn[37] in a factory where they found that women placed less emphasis upon earnings as a motivating influence than the men who worked there.

When we consider some characteristics of the ancillary occupations, we find that they can be defined as workers with secondary workforce features. Williams *et al.* found that many ancillaries were from immigrant groups[38]. These investigators also found that a substantial proportion of porters took a hospital job as a pre-retirement job after the age of forty. Haywood also found this to be the case with porters[39]. My own investigation supports this view. In two of the hospitals that I studied, the vast majority in the teaching hospital were over the age of forty when they took a porter's job. In another large hospital, over 30% of the porters were in this position .

When we consider the maintenance craftsmen we also find that a considerable number of them entered their hospital jobs after the age of forty and that they came from industries such as mining, which were declining in the locality.

There is also some evidence that ancillary workers have not enjoyed the best of health and they have looked to hospital occupations

for jobs that are not physically demanding. The N.B.P.I. Report established that 11% of the ancillary workforce were registered disabled workers. The study undertaken by Derby Council into the health of ambulance workers found that many suffered from ill health of one form or another before entering ambulance work.

It is, then, reasonable to point out that the majority of hospital workers in the non-professional jobs have one or more of the characteristics associated with the secondary labour market. This might well be the main reason why almost all of these occupational groups have low wage rates.

Halmos[40] expressed the view that personal service workers were entitled to enjoy the material benefits that other sectors of the working population enjoyed. But we can see from the data in the preceding tables that ancillaries have, in the main, consistently lagged behind other manual workers. This is also true of nurses when compared with non manual female workers in other occupations. The same applies to para-medical, scientific and administrative and clerical staff. The only occupational group which has consistently been in a favourable position relative to comparative groups outside the NHS, is the consultants. It should, however, be noted that, within the group of consultants, some of them have higher incomes than others. The most privileged section of the consultants have been those surgeons and physicians who have been involved in part-time consultancy work.

It has been established that the number of part-time consultants has declined over the last decade, but they still represent 42.8%

of all NHS consultants. It is, however, important to note that the highest proportion of consultants involved in part-time consultancy in the NHS are in surgery specialisms and the lowest in pathology, geriatrics and mental handicap care. This reflects the market value of the consultants in particular areas.[41]

When we consider the earnings of part-time consultants, we find that the Review Body on Doctors and Dentists' Remuneration Cmnd 7544 Report of 1974 indicated that 'one third of their income' was derived from private practice.

It is arguable that, with the exception of the hospital consultants and a small percentage of senior health administrators, most hospital workers, be they in professional or non-professional occupations, earn less than workers in comparable groups outside the public sector.

We need to consider some of the historical and social reasons for the position that prevails today. We know that when the BMA conducted negotiations about the terms and conditions for entering the NHS in 1948, hospital consultants and dentists were in a much stronger position than any of the other occupational groups to negotiate an acceptable position for entering the NHS (Willcocks[42]). It is not too much of an exaggeration to say that most of the other occupational groups had to follow the lead determined by the BMA.

It is also worth considering the bargaining position of nurses. The first point to note is that, with the exception of an elite group of nurses, many of the early nurses were recruited from women

who were prepared to work for low wages and accept the hard conditions of service. Secondly, the vast majority of nurses in the early post-war period of the 50s were single women and a substantial number of them lived in residential nursing homes. There was a strong element of paternalism pervading relationships between nurses and their superiors. In spite of the growing influence of the Royal College of Nurses, nurses have always been reluctant to impose industrial sanctions to improve their economic position. This lack of militancy might also be reinforced by the marital status of many nurses who are employed on a part-time basis. These are some of the reasons which might help to explain why nurses who are still predominantly women have been exploited by society at large. Their commitment to patient care has rarely been questioned but the sad fact is that they have not been appreciated in material terms for their efforts. It should also be noted that, whilst they earn as much as some non-manual female, and more than manual females, they also work more unsocial hours than others.

When we consider that the other occupational groups in hospitals also have a high percentage of female workers, we can appreciate the point made by Bishop about hospital workers being defined as workers in a 'secondary labour market'[43]. But strikes and sanctions in the NHS have made a considerable impression upon the hospital work culture.

It is also worth considering that high rates of absenteeism and high rates of labour turnover are associated with organisations that employ workers from what is described as a 'secondary labour

market'. Hyman also made the point that absenteeism and labour turnover often indicate dissatisfaction in a labour force that is not highly unionised or militant[44].

Labour turnover and absenteeism

Labour turnover

The NBPI 169 Report in 1971, which investigated the productivity of hospital ancillaries, recognised the problem of labour wastage that hospital administrators have to cope with. The Report established that the crude rate of labour turnover was higher in the case of ancillary workers than it was in industry in general. The crude rate for male ancillaries in hospitals was 42%, whilst in industry in general, other workers had a crude rate of 32%. Female ancillaries had a crude rate of labour turnover of 53% whilst the rate for all female workers in other industries was 52% .

The NBPI statistics suggest that the problem of labour wastage was just as acute in hospitals as it was in industry. Other studies of labour turnover have also established that hospitals have just as much difficulty in retaining manual workers as have other organisations. The findings of Williams *et al.*, in their studies of two London hospitals, indicated that during the period 1971 to 1975, crude labour turnover ranged from 77% for male ancillaries in 1971 to 38.3% in 1975[45]. In the case of the female ancillaries the crude rate was 60.7% in 1971 and 27.9% in 1975. These sociologists did not, however, arrive at the conclusion that labour wastage was a bigger problem in hospitals in the case of manual

workers than in the manufacturing industry because the statistics for the latter group embraced managerial and other white collar workers . But it clearly was a major problem to retain hospital ancillaries.

Williams *et al.* drew attention to three important points. First, they suggested that the crude rate of turnover among male ancillaries was higher than females because their earnings were less favourable than that of the females in relation to their counterparts in industrial occupations. The second point was that the rate of turnover was higher among males and females in the first year of their employment than in the succeeding years. Thirdly, they noted that younger ancillaries were more liable to leave in the first year than the older ones[46].

Jeffries[47], in a study of labour wastage in a South Wales hospital (which happened to be one of the hospitals that I am concerned with in my particular study), identified a serious problem of labour turnover amongst domestic workers. He established that, during the years 1972, 1973 and 1974, the crude rate of labour turnover for this group, on the basis of a mean average, was 50%. He also established that the loss of domestic staff was much higher during the first year than for any other year. In this respect he stressed the critical nature of the first year for training and preparing new workers for hospital work and supports the views expressed by Williams *et al.*[48]. Jeffries also drew attention to the problem of labour stability and he found that the percentage of people who had been in the establishment for over a year in 1972

was 74% and, in 1974, was 83%. He also found that when he examined the records of the majority of leavers during this three-year period, 67% of the leavers were in the avoidable category .

I also made a limited investigation into the problem of labour turnover among ancillary workers. It was limited because I was not able to have access to the personnel records for all of the ancillary groups in the hospital in which I was interested. Another limitation was that the records that I could refer to, did not always relate to a comparable period in time, because I was only able to have access to ambulance statistics for the latter years of the 70s.

In Table 28 I will show the pattern of labour wastage for four of the occupational groups that I have referred to (who also came from some of the hospitals that the ancillaries in this study were drawn from). These statistics, together with those obtained by Jeffries[49] should be of some value in indicating the extent to which ancillary workers became attached to the caring work that they were employed in. Most of the observations that I have made in this study have been based on the examination of the attitudes expressed by ancillaries. The data on labour turnover relates to actual work behaviour and might support the perspective that I have obtained about occupational attitudes, or cast some doubt on it.

TABLE 28

THE YEARLY AVERAGE RATE OF LABOUR TURNOVER FOR ANCILLARIES OVER A THREE YEAR PERIOD IN THE SEVENTIES

REASON FOR LEAVING	OCCUPATIONAL GROUPS							
	AMBULANCE (n = 174)		THEATRE (n = 26)*		PORTERS (n = 99)*		CRAFTSMEN (n = 50)*	
Avoidable	N 12	6.9%	N 6	23%	N 8.3	8.4%	N 1.3	2.6%
Unavoidable	N 10	5.7%	N 1.3	5.3%	N 5.3	5.5%	N 4.7	9.4%
Yearly average	N 22	12.6%	N 7.3	28.3%	N 13.6	13.9%	N 6	12%
3 year total	N 66		N 22		N 41		N 18	

* from the large hospital (teaching)

n = number in the establishment

If we now relate the data in Table 29 above to the Halmos argument relating to personal service orientation, we find that the theatre assistants, the occupational group which should be more firmly integrated within the personal service professional culture than any of the other groups, had a higher rate of avoidable labour turnover than any of the other groups. I also established that most of the leavers left with less than one year's service. When I examined the medium size hospital I found a crude labour turnover rate of 27% with most of the leavers leaving with less than one year's service .

Whilst the theatre assistants were the ancillaries with the highest scores in terms of intrinsic involvement in work, and also marginally in personal service orientation, they were more prone to leave the hospital than porters or maintenance craftsmen. It is also relevant to note that the theatre assistants were more intrinsically

orientated to hospital work in terms of their expectations than any of the other ancillary groups looked at in this survey. Whilst I have no firm evidence about the reasons for leaving, my investigation into the explanations that theatre assistants gave when leaving and the knowledge that the senior theatre assistants in the two hospitals had about the leavers, indicated that they left for better paid jobs. This suggests that although intrinsic expectations might be an important determinant of job choice, extrinsic considerations are of particular importance as determinants of remaining in a job.

When we consider the position of ambulance workers who had lower rates of avoidable turnover than theatre assistants, we find that they have jobs which can be as intrinsically involving as those of theatre assistants but they were induced to stay longer because of their higher wage rates. In the case of the porters, the average loss of porters was lower than that for the theatre assistants in both hospitals. This also applied to the maintenance craftsmen. In view of the fact that the ancillaries in both of these occupational groups placed more weight on security as a reason for entering hospital work, and also as a source of satisfaction, they might be less concerned about wages than the theatre assistants, who tended to be in the under-forty age group.

In view of the fact that I was only able to obtain information concerning the ages of the porters in the teaching hospital and in the medium size hospital, and this information for the theatre assistants in the teaching hospital, one can only consider the

relationship between age and labour turnover for the two occupational groups in these hospitals. I found that the theatre assistants lost 43% of the under thirty age group. In the case of the porters in the teaching hospital, 23% of the leavers came from the under thirty age group. I also found that in both of these occupational groups, the majority of the leavers left with less than a year's service in the hospital job.

I examined the relationship between age and leaving for these two groups over a seven year period and found that the majority of the leavers in both groups were under thirty and had been employed for less than a year. These findings tend to support the findings of Jeffries[50] and Williams *et al.*[51] who stressed the importance of the first year in hospital work. Whilst this problem exists in industrial organisations it certainly stresses the need to be careful in the selection, induction and training of ancillary staff.

Absenteeism

The third indicator is the rate of absenteeism in organisations. Absenteeism can take two forms; certified absenteeism, which is attributed to sickness or injury which is legitimised by the doctor as a reason for not working, and a second form of absenteeism which is uncertified and is usually of a short duration ranging from a day to three days. In view of the fact that there might be some doubt about the authenticity of certified absenteeism, many personnel departments refer to absenteeism, whether in the form of uncertified or certified, as an indicator of some degree of

dissatisfaction in work. Most studies of absenteeism, such as the yearly reports published by the researchers of the Office Health Economics, show that manual workers tend to be absent from work more frequently than non-manual workers and they suggest that the former group are less satisfied with their work than the latter group. Indeed, the Office of Health Economics found a close association between high absenteeism and low job satisfaction.[52]

Most of the studies of ansenteeism which have been concerned with hospital ancillaries drew attention to the serious nature of the problem for managers. Williams *et al.*[53], in their study of two hospitals, established that male ancillaries lost an average 18.1 days per year and an average of 3.6 spells a year. Female ancillaries lost an average of 24 days a year and had an average of 4. spells of absenteeism every year. Whilst this study did not differentiate between the occupational groups in the ancillary workforce of the two London hospitals, the findings suggested that absenteeism was as much a problem in the hospital in the case of ancillaries as it is in industrial organisations.

There are also two studies of two hospitals in a South Wales city into absenteeism. One study by Jeffries[54] into absenteeism among domestics, found that it was high enough to represent a serious problem for hospital administrators. The average numbers of days lost for 1973, 1974 and 1975 were 12.07, 15.01 and 14.07 respectively, with the corresponding number of spells 5.25, 6.2 and 6.01.

Rice investigated the degree of absenteeism among ancillary

and clerical occupational groups in the medium size hospital in which I am interested for this particular study.[55] This study was concerned with porters, domestics and clerical workers. Rice found that the mean number of days lost for porters was 11.4 days and the mean number of spells, 3.4. Domestics also had lost an average 11.4 days a year and their mean number of spells was 2.1. The clerical workers who were surveyed worked in the Administrative and Clerical Department and in the Medical Records Department. In the former department the mean average days lost was 2.2 and the mean number of spells 0.7. In the latter department the mean number of days lost was 3.9 and the mean number of spells was 1.4.

It is evident that the clerical workers were less of a problem than domestics and porters in respect of absenteeism and these findings suggest that white collar workers in hospitals might be more attached to their work than the porters and domestics. In this respect they are on a par with other industrial organisations.

Whilst the porters and domestics lost a substantial proportion of working days due to absenteeism, it is important to know how they compared with male and female workers in other industries. If we refer to the statistics published by the Office of Health Economics on absenteeism for 1974, we find that semi skilled manual and personal service workers lost an average 11.5 days a year and unskilled manuals 18.4 days a year. If we compare the porters with these two broad occupational groups we find that they were marginally better than the semi skilled workers and considerably

better than the unskilled workers.

When we compare the domestics with females in semi skilled occupations, who lost an average 7.4 days, and with unskilled manual females who lost an average 8.5 days, we find their position is less favourable.

Whilst these statistics might be regarded as crude indicators of work relationships, they do not provide strong support for the view that ancillaries working in hospitals have a stronger attachment to their work than manual workers in other industries. This suggests that the data available on absenteeism for ancillaries does not favour the Halmos hypothesis for hospital ancillaries .

The Changes in the hospital work culture

The problems of industrial sanctions, absenteeism and labour turnover in the last decade reflects the industrialisation of a personal service work culture. The use of sanctions has created considerable difficulties for hospital personnel who have been forced to cope with the dilemma of neglecting the patient in one way or another if they become involved in a dispute and enforce industrial sanctions, such as the withdrawal of labour. Industrial action has been pursued by ancillaries, in the form of strikes, junior doctors have placed an embargo upon overtime working, many of the para-medicals who belong to trade unions have also engaged in industrial sanctions. Whilst consultants have not resorted to withdrawing their services, they have threatened to do so over such controversial issues as pay beds. The occupational group which has not engaged in the use of sanctions which might harm the patient

are the nurses who belong to the Royal College of Nurses, and it is important to note that the use of strikes is forbidden to their constitution.

It is evident that hospital workers who resort to strike sanctions and, indeed, other sanctions might feel torn between loyalty to their trade union or professional body and loyalty to the patient. This form of conflict might be defined as inter-sender role conflict. It can also be viewed as a personal value conflict between the worker's commitment to the value of patient care and concern for improving material living standards. This might also be regarded as a conflict between intrinsic and extrinsic considerations. This type of conflict is inherent in the role of personal service professionals. Professional values stress the importance of providing a service whilst trade union values are concerned with the contractual relationship between employer and employee.

The use of industrial sanctions in the hospital service can be seen as a new element which is changing the norms and values of the hospital sub-culture. We have noted in Chapter Two how bureaucratic pressures in the hospital have influenced the values of the nurse and how it has also changed the role concept of professional nurses. Industrial sanctions can also influence the role concept of hospital workers. The overall impact of a change in the role concept of hospital workers. The overall impact of a change in the role concept of hospital workers may well change the organisational norms of the hospital and weaken the norm of commitment to the patient.

The hospital, as an institution, has been dependent upon the

the hospital worker internalising the norms of the hospital organisation. A weakening of the norm of complete commitment to patient care, together with the impact of bureaucratisation in hospitals, might strongly threaten the personal service aspect of hospital work and shift the hospital workers' role to a more impersonal relationship between them and the patient.

If we look at the pattern of industrial disputes in the hospital service, we find that the most important issues over the last five years have been concerned with wages and salaries, followed by opposition to a private sector of patient care existing within the health service. The hospitals have also been embroiled in a number of disputes over a wide range of substantive issues, such as wages, bonuses and incentive payment schemes and procedural issues concerned with grievances and discipline and even redundancy.

It is evident that ancillary workers who strive to improve their social and economic position in a professional milieu will experience some degree of role strain. The theatre assistants experience strain in their persuasive negotiations with nurses and consultants to be accepted as para-professionals in the operating team. Ambulance workers, who are more militant than theatre assistants, experience strain when the industrial action they take may harm the patient.

Summary

In this chapter I examined the nature of the economic and social rewards that ancillary workers obtained and I examined the nature of their economic and social aspirations. Whilst I noted in Chapter Three that ancillary workers were primarily concerned with extrinsic rewards, it is evident from the findings in this chapter that, for most male ancillaries, the extrinsic rewards in the form of earned income compared unfavourably with the earnings of manual workers in industrial organisations, although this does not apply to the female ancillaries to such an extent.

I also noted that ancillary workers have become more conscious of their economic position relative to that of other workers and this is reflected in the increasing number of industrial disputes in the NHS, which in turn reflected the influence that industrial values and norms were exerting in hospital organisations.

I also noted the concern which certain ancillary workers had about improving their occupational status, and this concern re-affirms many of the comments expressed by some of the ancillaries in Chatper Five. In that chapter I referred to some of the comments which suggested that some ancillaries, such as theatre assistants, porters and domestics were very sensitive about their low status position. In this chapter I indicated that porters and domestics were not very involved in activities aimed at improving their status, although the formation of the Head Porters' Association might represent a growing awareness of their social status in hospital organisations.

The low form of involvement of these two groups differed significantly from a higher form of involvement by the ambulance workers and theatre assistants, who had taken steps to form para-medical type professional associations to promote their efforts to improve their status.

The differences in the striving for status between these two broad groups might well reflect their different aspirations. Domestics in particular, although not as intrinsically involved as theatre assistants and ambulance workers, might be more resigned to accepting a low status position as long as their extrinsic expectations are met. This, however, might not be the case with the ambulance workers and theatre assistants, who want both extrinsic and intrinsic rewards. Ambulance workers, through their militancy, have demonstrated how far they are prepared to go to obtain extrinsic satisfactions. Theatre assistants might be more reluctant because they are too closely involved in the highly sensitive professional operating department team of nurses and medicals. But both of these groups also want intrinsic satisfaction from work. Halmos was surely correct when he talked about the stimulating nature of caring work that demanded skills and commitment. Where he was probably wrong was in his assumption that, where there were intrinsic rewards, extrinsic ones would surely follow or, if not, they would be of secondary importance .

The findings in this chapter demonstrate that low paid workers in intrinsically stimulating occupations will compare themselves with such comparator groups as doctors within the caring profession or

with those in non caring occupations whose earnings provide the basis for better material standards in a society which places as much, or more, stress on consumer behaviour as it does on the need for caring values.

If the values of personal service orientation exerted the type of influence that Halmos assumed they would, there would be less conflict in our caring services and people in caring occupations would not have to undergo the surely brutalising experiences of introducing industrial sanctions which must harm the patients in various forms, however much attention is paid to codes of behaviour .

Industrial disputes in the NHS will also harden the lines between those in managerial positions and those who are managed. When surgeons and administrators undertake ancillary work during a dispute it might help them to understand the importance of some of the ancillary jobs, but it might well produce the 'us and them' attitudes so characteristic of industrial organisations. So instead of the integrationist influence of the professionals envisaged by Halmos, we are witnessing an increasing degree of bitterness and division among caring workers in hospitals at all occupational levels, not to mention the harm to the patients .

In this chapter, I have examined the economic and social aspirations of hospital ancillary workers and it is important to note some of the implications of these findings for the explanation of personal service orientation. Halmos hypothesised that the most important and influential personal service professionals would tend to encourage subordinate professional and non professional groups to

maximise their contribution to patient care and that one of the consequences of this would be the enhancement of the occupational status of these groups. He also argued that the striving for occupational status and improved economic rewards were not incompatible with maximising their contribution to patient care. Indeed, he implied that it was quite proper to pursue these social and economic benefits .

The evidence of this chapter which relates to these aspirations suggests that there might well be some degree of difficulty in preserving or improving the economic and social position of the most influential groups whilst also raising the corresponding positions of subordinate groups.

The main example that I have presented is the one which relates to the theatre assistants and the theatre nurses. The difference in the earnings between the trained theatre assistants and the State and Enrolled theatre nurses was not of major significance, but yet it was real enough to be a source of contention between these occupational groups. This cannot be merely attributed to a protective and narrow attitude on the part of the theatre nurses who are not concerned with patient care because it has much deeper roots. Theatre nurses who are trained realise that their financial rewards are in no way compatible with the rewards for surgeons and anaesthetists and they might well consider the emergence of the theatre assistant as a threat to their well earned position and modest gains in hospital organisations.

Whilst theatre nurses are not prepared to adopt industrial

sanctions to improve their economic and social position, they are prepared to resort to well-established industrial practices to protect their position by ensuring that they establish lines of demarcation between themselves and theatre assistants. It is interesting to note that in protecting their position they appeal to the caring ideology. It is worth noting that patients tend to be excluded from the debate about the respective merits of both groups and there appears to be few opportunities for the patients who require this caring service to contribute to the debate because they do not belong to a pressure group and place their trust in the medical profession and the administrative staff in the hospital service to protect their interests.

CHAPTER SEVEN

CONCLUSION

The theoretical issues

In this study I have described the nature of the work of five ancillary occupational groups and I indicated how this work contributed to patient care. I also indicated that most of the ancillaries recognised that they were making this contribution. Most of the ancillaries were in frequent contact with nurses in their work and one occupational group, the theatre assistants, were also in frequent contact with consultants and other doctors. The theatre assistants were very closely involved in the type of personal service professional culture that Halmos[1] considered to be an important socialising influence in determining a personal service orientation among the workers who participated in it.

The nature of the work of the theatre assistants and their relationships with medical and nursing groups provided an excellent opportunity to test two of the main hypotheses advance by Halmos[2] about the nature of personal service orientation as a form of intrinsic involvement in work.

In this study I set out to test two hypotheses. First, I tested the hypothesis that ancillaries who worked in a personal service professional culture would develop a personal service orientation. Secondly, I tested the hypothesis that the main determinant of this orientation was the support and tutelage of personal service professionals whom the ancillaries worked with. In testing these hypotheses, I also had the opportunity to consider the extent to which

the satisfactions that helping workers had from their work differed from the satisfaction of other workers. I was particularly interested in comparing the components of the three values of personal service orientation, with the components of other forms of intrinsic involvement in work, defined by sociologists who had studied industrial situations.

Before I proceeded with my empirical research I examined the literature relating to the pattern of work involvement of personal service workers that had been described in the published findings of those personal service sociologists who had studied the work role of nurses and hospital ancillaries. Both of these groups were of particular relevance to a study which looked at the interacting relationships between personal service professionals such as nurses and ancillaries that supported them.

In view of the fact that Halmos[3] placed more stress on the socialising experiences of personal service professionals than he did upon the expectations they brought to their work, I referred to the literature relating to the importance that other sociologists placed upon work expectations as determinants of work satisfaction in Chapter One. I established in this chapter that personal service workers did not differ in a significant way from undustrial workers in respect of the value they placed upon extrinsic considerations, which they tended to consider more important than intrinsic ones. It was, however, interesting to note that the professional personal service workers and industrial managers and other professional workers had better opportunities

to enter work which was intrinsically satisfying, than hospital ancillaries or manual workers in industry.

In Chapter Two, I examined the nature of the work experiences involvement and satisfactions that nurses and ancillaries derived from caring work. I wanted to know the extent to which other personal service sociologists had come to similar conclusions to those of Halmos[4] in respect of the components of the three values of personal service orientation, as defined by Halmos[5].

I was also interested in comparing the nature of intrinsically satisfying work in caring occupations with that of industrial workers. How did the personal service worker differ in respect of his emotional involvement in his work? Did they differ in a significant way from the printers described by Blauner?[6] An examination of the main components of the three values of personal service orientation indicated that they had a great deal in common with components of intrinsic involvement in work, which industrial sociologists such as Blauner[7], Faunce[8] and Shepard[9] referred to in their studies of industrial organisations.

If we consider the first value, we note that Halmos[10] referred to the application of skill and knowledge in the meaningful and intrinsically rewarding and satisfying work of helping people in need. Blauner[11] also stressed the importance of the use of skills and the development of knowledge in meaningful work related to material end products as the components of intrinsic involvement in industrial work. Blauner[12] also referred to the importance of work place participation as a component of intrinsic involvement

for industrial workers. Hespe and Wall[13] also appreciated the importance of this component for nurses at all grades within the hospital structure. Halmos[14], on the other hand, did not appear to recognise the importance of this component.

In order to establish the degree to which ancillaries in hospital work expressed the type of intrinsic involvement that would satisfy the criteria set down by Halmos[15] for the first value, and also for the criteria that would satisfy industrial sociologists such as Blauner[16], I added the component of work place participation to the three components of the first value as defined by Halmos.

In discussion of the literature in Chapter Two, I noted that many of the personal service sociologists placed less emphasis than Halmos[17] upon the value of 'concerned empathy'. Halmos considered this to be an essential value for all caring workers. However, sociologists such as Anderson[18] and Brown[19] argued that it was not always possible for all nurses to establish close personal relationships with patients, although some degree of empathy was necessary. These considerations suggested that there was a need for a less demanding definition of empathy for many caring workers, and this would certainly apply to non-professional caring workers such as hospital ancillaries.

I indicated earlier in this study that, whilst Halmos[20] defined the first two values of personal service orientation and their components in a precise manner, he was not as precise when he came to the third value, which he defined as professional integrity,

or, in the context of this study, occupational integrity.

Halmos[21] suggested one limitation when he made the point that the prerequisite to the expression of the third value was that caring workers had to express both the first and the second values. In view of the fact that there were wider opportunities for expressing the first value than there were for expressing the second, this precondition might be too restricting. Halmos[22] also stressed that the main characteristic of the third value was the ability of the helper to demonstrate to the helpee that he or she was helping and empathising effectively. This condition might preclude certain helpers such as theatre assistants, who, unlike theatre nurses who nursed post-operative patients, only had limited contact with patients on a personal basis. He then referred in more general terms to the third value being manifested by evidence that personal service workers were maximising their role performance, and that they were firmly integrated within the personal service professional culture.

In view of these limitations, I presented a definition of the third value of occupational integrity in a way that took into account the occupational constraints referred to, but which would be in accord with the notion of the type of integrity that would apply to all caring workers who were proud of their contribution to patient care. In my view, caring workers could be strongly orientated towards the first or the second value without satisfying the criteria for expressing the third value. A theatre assistant might satisfy the criteria for the first value but not for the second, or the porter might satisfy the criteria for the

second value but not for the first. They could, however, both have integrity or a sense of wholeness on the basis of their particular contribution to patient care.

When I referred to the third value of personal service orientation in the introductory chapter, I noted the affinity between this value and the concept of self-esteem which industrial sociologists referred to. It is interesting to note that Wilensky[23] noted the relationship between intrinsic involvement in work and the self image of the worker. This sociologist referred to 'a prized image' that individual workers would have of themselves. He made the point that if workers had the opportunities to 'realise their personal attributes in work' they could develop a favourable self image.

Shepard[24] also stressed the importance of recognition from significant others as an important factor in nurturing self-esteem. If peoples' efforts at work were recognised and appreciated, then this should encourage workers to build a favourable image of themselves and this would prevent them from becoming alienated from their work. The points made by Shepard[25] and Wilensky[26] might well be challenged by some industrial sociologists, but I have mentioned them to demonstrate that the value of professional integrity, or occupational integrity, described by Halmos[27] is a consideration that industrial sociologists have also recognised.

It can also be appreciated that the concept of 'self-esteem' might be very relevant to workers in hospitals, who had only limited opportunities to apply their skills and develop their knowledge

in work. Even if their contribution to patient care is a modest one, it should still merit some recognition from medical and nursing groups and this should promote some degree of occupational dignity among the lower skilled workers in the caring services.

In the discussion on my empirical research in Chapter Three, I described the main characteristics of the five ancillary occupational groups. I then discussed the data relating to their responses to the questionnaire. I established that most of the ancillaries had extrinsic expectations, with job security being the most important of them. I found that there were no significant differences in this respect between the five groups. I then examined the extent to which they expressed the first value of personal service orientation, which I had broadened to take into account the component of work place participation. I established that there were no significant differences between the ancillaries in respect of some of the components but there were on others. Most of the ancillaries saw their work as being meaningful and most of the ancillaries had low scores on work place participation. When I focused upon the components of intrinsic satisfaction in work and self-realisation, the theatre assistants and ambulance workers had the higher scores. When I measured the overall average score for the four components of the first value, the theatre assistants and ambulance workers had marginally higher scores than the other ancillaries. When I examined the extent to which the ancillaries expressed the second value, 'concerned empathy', I found that porters and ambulance workers had higher scores on this value than theatre assistants and domestics. This suggests that relation-

ships with patients was a source of greater stress in the latter two occupations than in the former two.

Theatre assistants and ambulance workers had a direct task relationship with patients and had a high measure of individual responsibility for their care, and this could inhibit them from being too friendly with patients. In the particular case of the theatre assistants, they often only met patients prior to the operation they received on only one occasion. They would rarely enter into a situation where they could develop a personal relationship with patients in view of the fact that immediate post-operative nursing was the special responsibility of nurses.

Halmos[28] argued that ancillaries would express the third value of personal service orientation if they could demonstrate to the patients that they were maximising their performance in their caring role. I sought the evidence relating to the third value in Chapters Four and Five, by examining the extent to which ancillary workers perceived that they were firmly integrated within the personal service professional culture.

In view of the fact that all the ancillaries were in some degree of contact with nurses in their work, nurses would represent an important reference group for ancillaries who wanted to maximis their caring contribution. In the context of the Halmos[29] hypothesis, nurses should play an important socialising role in helping to encourage and support the ancillaries who worked with them.

In Chapter Four I examined the nature of the relationships between

the ancillaries with nurses and also their relationships with medical groups, and I was particularly interested in the degree to which ancillaries felt that they were appreciated and encouraged by nurses to help patients.

In Chapter Five, I examined the degree of role strain experienced by ancillaries. If ancillaries had a high degree of support and experienced a low degree of role conflict in their relationships with nurses, this would suggest that they were firmly integrated into the personal service professional culture and could be considered as ancillaries who expressed the third value of personal service orientation. The study indicated that whilst theatre assistants (the occupational group most likely to express a strong personal service orientation on the basis of the Halmos[30] hypothesis) were only marginally more personal service orientated than the other four groups, there was some variation between the theatre assistants employed in the large teaching hospital and those in the medium-sized hospital.

In Chapters Four and Five, I established that the relationships between theatre assistants and nurses were not as favourable as Halmos[31] envisaged on the basis of his hypothesis on personal service professional support. It was evident that one cause of the strain in these relationships was related to the aspirations of theatre assistants to improve their occupational status.

In Chapter Six I pursued this interest in improving the occupational status in more depth. I wanted to know the extent to which ancillaries wanted to improve their occupational identity

and status and to consider the extent to which these aspirations were determined by the ancillaries' involvement in the personal service professional culture. The determinants of these occupational aspirations are of particular relevance to the concept of personal service orientation as defined by Halmos[32]. He envisaged that the professionals would play a key role in nurturing and supporting these aspirations. I found no strong support for this view.

In this chapter I also explored the economic aspirations of the ancillaries. Whilst Halmos[33] argued that economic considerations were not the prime motivators of personal service professionals and other personal service workers, they were not incompatible with the expression of personal service orientation.

I established in this chapter that the social and economic aspirations of the ancillaries determined two types of conflict which have been identified by industrial sociologists concerned with conflict in industry. The first form of conflict has been described by Fox[34] as 'pluralistic conflict'. It relates to the conflicts that can arise out of the differences between various interest groups in organisations. Fox argued that not only could there be conflict between employers and workers but that there could be conflicts of interest within these broad groups and that occupational groups could be in conflict on certain issues, particularly those concerned with job protection. The second form of conflict has been illustrated by the various forms of industrial sanctions which hospital workers have taken against the government as their employer. The ancillary workers' strike in 1973 could

certainly be regarded as an expression of militancy by a group of low status employees who perceived themselves to be an under-privileged section of the hospital workforce.

In order to understand the nature of the conflicts which have strained relationships in the hospital service, it is necessary to understand the nature of its occupational structure. Lees[35], a health service economist, made the point, "The distinctive features of the professional activity are rules governing the behaviour of those belonging to the professional group and de-limiting the territory and making it difficult and often impossible for others outside the group to enter". Whilst Lees[36] expressed the view of an economist interested in advancing the case of private medicine, sociologists strongly opposed to the introduction of market forces in the health service have made similar comments. Waitzkin and Waterman[37] made the point,

> Nurses, aides, orderlies, ward clerks and medical social workers (to consider only a few occupational roles within the institution of medicine), generally take orders from above despite the widely recognised fact that these sub-ordinate health workers often understand more about patients' total needs and have more extensive daily con-tact with patients in clinics and hospitals. They generally can contribute little in decisions concerning patient management.

One can appreciate that a great deal of the pluralistic form of conflict in hospital organisations has been due to the aspirations of groups in subordinate positions striving to improve their status and, indeed, their contribution to patient care, who have found themselves in opposition to the position taken by the more established personal service professionals in medicine and nursing.

In this study I described the way in which theatre assistants were closely involved in the operating departments of a group of hospitals in a locality in South Wales. I made the point that this particular work situation exemplified the type of 'personal service professional culture' which Halmos described when making the case for the cultivation of personal service orientation within the work milieu of a personal service professional culture. I found that theatre assistants worked very closely with nurses and medical groups and that they were appreciated by these professional groups and, in general, had a much closer involvement with them than the other hospital ancillaries whom I investigated. But, I found that they were only marginally more intrinsically involved than ambulance workers and porters and, in this respect, did not express the first value of personal service orientation to a significantly greater degree than the other ancillaries.

I also found that they did not express the second value, concerned empathy, to the same extent as ambulance workers, porters and domestics. Although I explained that the stressful nature of the work of the theatre assistants and the remoteness of their personal contact with patients was not conducive to establishing close personal relationships with them. Neither was there firm evidence to suggest that theatre assistants had a greater degree of self esteem than the other ancillaries which would enable them to express the third value of personal service orientation described by Halmos as the third value of personal service orientation, which was professional or occupational integrity.

It was quite evident that theatre assistants were, in theoretical terms, in a position to benefit from professional tutelage, particularly from the nurses. But it was also quite clear that nurses were reluctant to provide the type of support envisaged by Halmos, and that they perceived the theatre assistants as competitors in the traditional occupational territory of theatre nurses. What I found was not the type of personal service culture perceived by Halmos as one of tutelage and support, but one of role strain and tension.

When I measured the overall degree of personal service orientation expressed by ancillaries, I found that although theatre assistants emerged with the highest scores, the variation between the groups was not statistically significant at the 0.05 level when subjected to an analysis of variance test. It is quite evident that the theatre assistants had marginally higher scores than the other ancillaries, particularly in the first value of personal service orientation. But I cannot conclude from the data that as in their overall personal service orientation scores, the higher scores were related to the tutelage and support that the theatre assistants received from the medical and nursing groups in the operating department. A more reasonable explanation for the marginally higher scores of the theatre assistants is that the nature of the work, with its tasks and responsibilities, is an important determinant of work satisfaction and occupational integrity and self esteem. Dummer[38], a senior nursing officer, made the point that the satisfaction from theatre nursing "comes from the relationships with the patients and looking after them.

Equally the theatre nurse builds relationships with surgeons and anaesthetists; as the patient leans on her so does the surgeon". Whilst this senior nurse did not refer to the theatre assistant, it is reasonable to assume that the challenge of theatre work and the responsibility to the team for patient care and, in the case of the theatre assistant the relationships that he has with the anaesthetists, are important determinants of intrinsic involvement and occupational integrity.

Intrinsically rewarding tasks and the satisfactions derived from the social interaction in the operating theatre team should not, however, be confused with professional tutelage. The theatre assistants, on the basis of the Lewin Report, should be encouraged to participate in a wide range of anaesthetic and other tasks. This was not the case in the hospitals in the locality which I have studied and it is reasonable to argue that work satisfactions referred to have been shaped by the tasks and relationships that the theatre assistants were involved in within the operating department. It is reasonable to argue that these satisfactions were not solely determined by the tutelage of the medical and nursing groups. If we refer to Table A7 in Appendix A, we can see that there is no close association between nursing support and intrinsic involvement in work for any of the occupational groups.

When we consider that the theatre assistants had only marginally higher scores than ambulance workers on the first value (a group who were not as closely involved in the medical and nursing groups), we can appreciate the importance of occupational characteristics as

a determinant of intrinsic involvement.

Another point which is worth considering is that the theatre assistants had stronger intrinsic expectations than any of the other groups and this is illustrated in Table 2 on page 87. It can be inferred that there is a closer association between intrinsic expectations and intrinsic involvement in work than there is between intrinsic involvement and nursing support. A close perusal of the statistical tables indicates that, where there are significant variations between the occupational groups in respect of their intrinsic involvement in work, the sharpest differences are not between the theatre assistants and the other four ancillary groups but between the domestics who are females and the other ancillaries who are in predominantly male occupations. This suggests that the domestics in the hospital service express similar attitudes to work that women in industry express. The point made by Beynon and Blackburn[39] about women being less intrinsically involved in their work than men is of particular relevance in this respect.

One can appreciate that there are specific reasons why the theatre assistants did not have the type of support and tutelage that Halmos envisaged. Some of the reasons have been appreciated by those sociologists who have studied the strains in the relationships between occupational groups in industrial and in personal service organisations and are of theoretical importance.

Strauss[40] has referred to the tensions that can arise in hospitals as a result of occupational groups striving to achieve professional status in what he described as 'professional locales'. Abel Smith[41], in his study of nurses, described the long process of negotiations that the government and administrative groups conducted with the Royal College of Nursing to enable unqualified and often untrained nurses to establish themselves as State Enrolled Nurses, and to be given the title of 'nurse' in the 1940s, when there was a need to increase the number of trained nurses during the critical wartime period.

The position of the theatre assistants and their relationships with nurses has certain similarities with the State Enrolled Nurses. The demand for theatre nurses in the 1970s and the need for more qualified support for nurses, surgeons and anaesthetists was mainly responsible for the emergence of the theatre assistants as a clearly defined occupational group.

On the basis of the Halmos[42] hypothesis that senior personal service professionals would support new personal service occupations, one might have assumed that the majority of consultants and theatre nursing personnel would be in the vanguard of advancing the case of the theatre assistants. This was certainly not the perception of many of the theatre assistants in this study, and a perusal of the journal of the theatre assistants, *Technic*, and that of the nurses in their professional journal *NATN News** indicates how controversial the case of the theatre assistants has been in professional circles

* NATN - News National Association of Theatre Nurses

in hospital organisations. This controversy illustrates two important points. First, that emerging occupational gorups who seek professional status do not depend entirely upon the support of the more established professions for legitimising their aspirations. They also look for support from senior administrative personnel in the DHSS and in the Area Health Authorities, and from the trade unions to which they belong. This suggests that theatre assistants have to engage in the politics of hospital organisations and they have to fight strenuously to advance their case at two levels. At the first level they must negotiate some degree of legitimacy in their hospital situation and at the second level they should gain national recognition through being taken off the Whitley Staff Council which caters for ancillary workers and be placed in the Professional and Technical Council B.

The second point which the relationships between theatre assistants and theatre nurses illustrates, is that occupational groups in caring organisations can emphasise their commitment to a caring ideology to protect their respective positions. Nurses who have opposed theatre nurses encroaching upon their traditional areas of work have often done so on the basis of protecting the interests of the patient. Theatre assistants have argued that to deny them the opportunity to learn and apply their knowledge and skills is detrimental to patient care. This suggests that even in such an important caring area as the operating theatre, people will work together on clearly defined and negotiated terms, and that it is the outcome of the negotiations rather than the commitment of the personal service professionals which will ultimately

determine the position of the theatre assistants.

It is evident that, during the period when theatre assistants are negotiating their position, they will experience varying degrees of role strain. In view of the fact that theatre assistants need the support of theatre nurses, and because they are perceived to be a key reference group in the operating departments, they must win the nurses' support before they can establish a firm occupational identity. Indeed, the efforts of the theatre assistants to cultivate an occupational identity which establishes them as part of the operating department team, but in a role that is separate from that of the nurse yet complementary to it, illustrates the four elements of work identification described by Becker[43]. These elements are; an occupational title, occupational ideology, commitment to work tasks and commitment to an organisation.

Katan[44], in a study of the problems of non professionals seeking recognition in a professionally dominated milieu, illustrated the strain they experienced. He argues that some non professionals seek recognition by following a conformist role which would not challenge the work areas valued by professionals. Others might pursue an innovatory role which would contest the professionals over certain work areas and practices. This problem also exists in the case of the theatre assistants. It is apparent from a perusal of their journal *Technic*, that most theatre assistants are willing to confine their work activities to the area of anaesthetics, an area which nurses are not particularly concerned with. But, the voice of the innovators is expressed by Williams[45], an

experienced and established theatre assistant, who makes this point. "Nurses tend to criticise operating department assistants because they want to protect 'certain hallowed' areas such as the table - or at least permit the minimum experience demanded by the training course and no more". He argued that theatre assistants have specialist expertise and that there should be scope for them to apply it in theatre work.

Studies of the work undertaken by theatre assistants in other countries confirms the view expressed by Williams[46]. In a study of hospitals in Holland, Bell[47] found that theatre assistants there pursued a three-year course which enabled them to specialise in either surgery or anaesthetics, with basic competence in both areas. She found that these assistants were allowed to work in either surgery or anaesthetics after their training and their role was acceptable to the nurses and medical groups employed in theatre work. It is, however, relevant to note that there was a critical shortage of theatre personnel in Holland and this probably provided a more favourable basis for employing theatre assistants in work which was not contested by nurses. In this country, as in many others, nurses have been exploited because of their weak bargaining position when marketing their skills and it is understandable that they feel insecure in their relationships with theatre assistants.

The disputed position of the theatre assistants in the operating department team suggests that they belong to a marginal occupation. Salaman[48] made the point that "an occupation can be

described as marginal when members wish to identify, and wish to associate with members of a higher status group and when these associational ambitions are unsuccessful". This description of the marginal group certainly applies to the position of the theatre assistants and their occupational identity and status.

Whilst theatre assistants look to the surgeons and anaesthetists for support, they do not directly threaten to encroach upon their traditional medical role. This, however, is not the case with the nurses. The theatre assistants seek parity of status with nurses and they want to be recognised for their specialist technical contribution to the operating department team. Whilst the personal relationships between individual nurses and individual theatre assistants might be cordial (and in this study I have found this to be the case), the conflicts arise when the work practices are determined by senior theatre nurses and medical groups within the hospital. A great deal will depend upon the willingness of the senior medical and nursing personnel and their response to the strength of the case presented by the theatre assistants.

The theatre assistants are not in a strong bargaining position and a great deal will depend upon local circumstances appertaining to the availability of nurses to work in the theatre. In this sense, the theatre assistants are appreciated when there is a critical need for their services and these are the occasions when they can demonstrate their effectiveness as members of the operating team.

Concern about the effectiveness of the theatre assistants has been expressed by senior theatre nurses when they were first introduced. Hudd[49] expressed concern about the training of non professional staff at the conference of theatre nurses in 1975, although she recognised the contribution to be made by trained technicians complementing the nurses in the theatre. This concern is still at the heart of the controversy.

Whilst the pluralistic form of conflict has been expressed most explicitly by theatre assistants, they also express another form of conflict when they resort to the use of industrial sanctions. It is important to note that most of the ancillary groups have been involved in imposing industrial sanctions of one form or another, and this has also been the case with some of the professional groups. This is evident from the statistics relating to industrial disputes in the NHS and the cause of these disputes*.

It is reasonable to argue that hospital workers are now, with certain reservations, willing to stand up to the government as an employer and to the managers who implement and interprete collective agreements. Many hospital workers realise that powerful and influential groups like the hospital consultants have been able to persuade governments of their value to the health service of this country, and other groups who want to raise their standards and status are resorting to less subtle methods to achieve their aims.

The embargo which the housemen placed on overtime to improve

* See the Royal Commission on the NHS Report, page 163

their income and conditions of service was as much a protest against the lack of support they had from the consultants and the British Medical Association as it was against the government. The formation of the Junior Hospital Doctors' Association to improve their bargaining position, is one example of the way in which medical groups want to influence their status and their recent merger with the Hospital Consultants' and Specialists' Association, to form the British Hospital Doctors' Federation, has considerable implications for professionalism and the concept of personal service orientation.

Whilst Halmos[50] perceived a merging of personal service professional groups to foster professional values, leading personal service professionals in the hospital service, such as consultants and junior doctors, have branched off from the British Medical Association to improve their bargaining position on contractual matters in the NHS.

Dimmock[51] has argued that the influence of the medical groups is not as great as it used to be and he has made this significant point, "The development of managerialism, professionalism and trade unionism has undermined the twin basis of medical influence and splendid isolation in hospitals". Administrators have taken away some of the power of the medicals, particularly on decisions relating to the allocation of limited resources. But, the influence of the medicals has also been weakened by the growing degree of independence exercised by professional nurses and para-medicals who want to be more involved in decisions relating to patient care. The power of the medicals is also being undermined by the

increasing influence of the non professional trade unions.

The medical influence in terms of its commitment to professional values is also being undermined from within. Dimmock[52] made the point that "The difference between professionalism and trade unionism has been gradually emerging throughout the 1960s and within the British Medical Association had maintained the form of professionalism while practising the substance of trade unionism". It is reasonable to suggest that other professional organisations in the hospital service, such as the Royal College of Nurses and the Society of Radiographers, have realised that they also need to place more emphasis upon their trade union functions within their professional framework. The fragmentation of the medical profession and its increasing concern on contractual matters, suggests that the values of personal service orientation have not been as strong as Halmos[53] anticipated as an integrating force.

The increasing influence of industrial values in the hospital work culture has also tended to undermine values of personal service orientation. Halmos[54] perceived the hospital workforce as a consensual team committed to professional caring values. What we find is increased conflict between professional and other occupational groups about the allocation of resources and rewards.

Industrial values are primarily based upon the recognition of market forces as a determinant of decisions relating to the most effective use of material and human resources. Hospital organisations have to take into account the constraints imposed by

by market considerations. Whilst the medical professionals have been the most influential pressure group in hospitals when decisions relating to the allocation of resources and priorities were taken, it is now evident that the non medical administrators have become increasingly involved in the decision-making process at various levels within the Area Health Authority structure.

In order to make the most effective use of resources, hospital administrators have introduced well-tried industrial methods of increasing productivity. The NBPI 169 Report made the point that productivity in hospitals could be improved through the introduction of work study bonus schemes, cost accounting and other industrial efficiency techniques. Hospital administrators have also placed a strong emphasis upon personnel management techniques with its concern for making the best use of human resources. The personnel function has also been involved in responding to the problems raised by the trade unions who have become much more militant in their response to the increasing influence of industrial values and methods within the sub-cultures of hospitals.

Halmos[55] argued that the values of personal service cultures would influence the values of industrial organisations. He did not, however, anticipate the extent to which industrial values would influence hospital and other personal service cultures. Hospitals, as organisations, embrace professional, managerial and trade union values and cannot be neatly described as professional locales. They are organisations which employ workers who belong to over forty occupational groups. Some of these have a strong

trade union orientation and range from the National Union of Employees, representing some ancillary workers, to the Hospital Consultants and Specialist Association and their Work Place Representatives. Many of the negotiated arrangements that have determined the scope for theatre assistants have much more in common with industrial work situations than the professional work cultures envisaged by Halmos[56]. In many hospitals it has been customary to establish a fixed ratio of theatre assistants to theatre nurses (usually in favour of the nurses). It has also been customary in some hospitals to vary the work activities of theatre assistants in accordance with the availability of nurses. In many hospitals it has also been traditional to allow the theatre assistants to work with professionals yet be responsible to the head porter or unit administrators on contractual matters and on disciplinary issues.

In many respects, the theatre assistants resemble the semi-skilled or the Government Trained Worker seeking acceptance in work cultures dominated by craftsmen. The Donovan Report of 1967 which identified this problem, expressed concern about the misuse of manpower in the economy when considering this issue. If we consider the problem of the theatre assistants in this context, then we are not making the best use of resources, and there must be some practical solution to the problem.

Halmos[57] perceived that there would be some degree of competition within the personal service professional culture, but his concept of competition perceived colleagues competing with each other to excel in respect of expertise. He did not consider the

extent to which there would be hard competition between interest groups within a professionally dominated work culture, with groups striving to prevent other groups from maximising their contribution.

The personal service professional culture should not be seen in idealistic terms as a work situation where participants are striving to help each other irrespective of the particular occupational group to which they belong. Personal service professionals, just like any other group of skilled workers, are mindful of the need to protect their hard won economic and social gains and will fight for them. It is evident that the model of professionalism as defined by Halmos is not a realistic one if we take into account the influence of bureaucratism and industrialism. It is also fair to comment upon the view that Halmos took upon the integrating influence exerted by the personal service professional culture.

If Halmos[58] maintained that the most influential personal service professional group would exert the strongest influence, then we should assume that the medical professionals would assume the leadership role in hospital organisations. Friedson[59] did not share this view and made this point about medicals and professionals, "Professional dominance equals medical dominance, doctors, initiate activity for all other in hospitals ...". It is evident that the medicals have clearly defined the nature of their caring role and have established very firmly the areas of autonomy which are specifically their domain. It is, however, important to note that

in defining their area of authority and autonomy, they have set limits to the areas of possible development of other caring professions such as the nurses and para-medicals. It is also evident that lines of demarcation are not only between medicals and other professional groups, but they also exist between nurses and other personal service professional groups and, indeed, between a wide range of occupational groups in hospital organisations. What we find in hospital organisations is not the merging of personal service professional groups as perceived by Halmos[60], but the development of what might be described as personal service professional differentiation. It is important to note that this development was envisaged by Willcocks[61], when he referred to the increasing number of professional associations in the NHS. Whilst all the groups stress the importance of their specific contribution to patient care, they also stress the complementary nature of this contribution to the work of others.

There is also evidence that this differentiation is not only to be found in the competitive aspirations of particular professional and occupational groups striving to define the limits of occupational territory. It also exists within professional and occupational groups. It has been noted that the State Enrolled Nurses were accepted into the Royal College of Nursing after considerable controversy and that there is no place for the auxiliary nurses within their professional organisation. It should also be noted that there is, too, further differentiation within the ranks of the State Registered Nurses, between those who become administrators and obtain the high status nursing jobs, and those who remain in work which is directly concerned with caring for the patient.

Johnson[62] has argued that the emergence of nurse administrators is a direct result of the influence of bureaucracy which has put nurses "into a them and us situation". She also argued that the nursing administrators were losing the respect of those nurses who were in close contact with patients, who were losing the traditional respect they had for the senior nurses in the profession. If there is any substance in the point expressed by Johnson[63], then it illustrates the way in which the influence of bureaucratism, with its emphasis upon the division of occupational tasks, procedures and a status hierarchy, can undermine the older values of professionalism with its emphasis upon the ability of professionals to deal with complex tasks in an individual way.

There is considerable evidence that as occupational groups become professionalised, they tend to discard many of the routine tasks, which are eventually taken over by other groups who will stress the importance of these tasks as a basis for developing a caring professional or occupational ideology. This has been the case within the nursing profession. Whilst such tasks as bathing the patient have been discarded by professional nurses in order to concentrate on specialist skills, auxiliary nurses have taken over this work for the patient and now claim to be doing an important job which demands recognition.

This consequence of the aspirations for professional status can also be found among the theatre assistants, who tend to discard some of the dirtier tasks to theatre porters or theatre orderlies, or domestics. Sometimes this is resented, particularly if the tasks do not provide the opportunity to uplift a worker's status in what

might be described as 'occupational scavenging'.

Halmos might well have over-estimated the availability of resources for the public sector concerned with the personal services, and also the shift of manpower to caring occupations. He might also have under-estimated the growth of private medicine and the impact it would have upon industrial societies where market forces are of importance in determining the distribution of economic resources. Sociologists such as Waitzkin and Waterman[64] who have studied hospital care in the USA, have argued that the commercialism of health care is undermining the service ethic and caring values among medical groups.

In view of the increasing interest in the UK in private medicine, it can be argued that the nature of the personal service professional culture as defined by Halmos[65] is changing, and that a stronger materialistic emphasis will be placed on the expectations of the medical professionals, and this will percolate down to the values of other professionals and non professionals. There is some concern that a two-tier health service will sharpen the differences between the style of life experienced by people with secure and well-paid jobs, and the increasing proportion of under-privileged people in this country. The problems of many patients and particularly those in long-stay institutions, will probably increase. Such developments will not promote the type of social integration envisaged by Halmos.

Having discussed the theoretical implications of the Halmos hypotheses, it is important to appreciate that the ideals outlined by Halmos are still of importance and there is a need to consider

some of the ways in which the contribution of hospital ancillaries can be improved if additional resources become available in the next decade. If, however, the resources are under even more pressure than they are now, then the manpower problem in the NHS will be in a critical state.

The Practical Implications

Selection and training

I will now consider the practical implications of my findings. In view of the fact that the NHS is a labour intensive service employing over a million workers, we can appreciate the point made by Willcocks[66] that manpower planning in this service is of prime importance. If we look at the particular position of ancillary workers, we need to consider the problem of manpower management in relation to the particular characteristics of the specific occupational groups.

Let us consider the domestics. Here we have an occupational group comprised in the main of female manual workers. Many of these workers are married women, who appreciate the nature of the convenient hours which they can work, which are compatible with their family responsibilities. There appears to be no problem in attracting such workers. Whilst they have a high rate of labour turnover, their position in this respect is not worse than the position of nurses according to some findings.

When we consider hospital porters, we also find that there is no problem in attracting porters. Many people find that hospital

work is not as arduous as many unskilled and semi skilled manual occupations. Sometimes workers tend to look at a porter's job as a second stage occupation, entering it in their middle age.

There are also no difficulties in attracting and retaining maintenance craftsmen. Whilst they come mainly from other industries and are probably attracted by the secure type of employment offered in hospitals, they probably become attached to particular hospitals.

There is also no problem in recruiting and retaining ambulance workers, but more consideration might well have to be paid to selecting those workers who will have the appropriate qualifications for the very demanding responsibilities of those who might be predominantly engaged in emergency service work.

Hospital organisations have tight lines of demarcation, just as industrial organisations have and, in my view, there would have to be a major reappraisal of the relationships between professional groups in hospitals and between professionals and non professionals if top priority was to be given to making full use of the personal resources of all hospital workers. If we start to make adjustments at the lower end of the occupational hierarchy, there would be a ripple effect which would disturb the upper echelons of hospital organisations.

There has been some consideration to the way in which nurses can upgrade their skills by encroaching upon the work of medical groups and there have also been strong reservations expressed by the medicals about developments in this direction. Many occupations

in the NHS have emerged as a result of some occupations becoming upskilled and shedding certain tasks to other occupations and this process will probably continue. We can appreciate that the theatre assistants were given certain taks which theatre nurses lost some interest in. The tasks which were shed were readily siezed by the theatre assistants, who perceived the potential for acquiring professional status from the tasks formerly the prerogative of theatre nurses. The theatre assistants were also interested in shedding some of their less attractive duties and these were allocated to a new occupational group, the theatre orderlies, and in some cases, to theatre porters and domestics. It might be argued that, contrary to the case presented by Halmos , personal service professional groups would forge a common personal service professional culture, but we find an increasing emphasis upon professional and occupational differentiation. Instead of the personal service professionals in the hospital service developing a closely knit integrated workforce, we find the proliferation of sectional interests and pluralistic conflicts in the service.

When we consider the theatre assistants, we need to consider the changing nature of their role. Many of the early theatre assistants were recruited from the ranks of the theatre porters and were assimilated into their new role on the basis of the recommendation of consultants and theatre nursing officers. Today, particular attention is being paid to attracting young people with suitable GCE O-level qualifications, who can study for the City and Guilds qualification. The calibre of these new recruits is a matter of concern for the British Association of Operating

Department Assistants, who are pressing their case for professional recognition.

In my view, there is a need for the Area Health Authority to establish a closer liaison with the schools in order to provide realistic information about the nature of the work of theatre assistants. Whilst ambulance workers are recruited from the ranks of mature age candidates, much more consideration should be given to attracting able people who want to work in a worthwhile personal service occupation.

Consideration should also be given to providing opportunities for people who enter ancillary occupations to upgrade their skills. At present there is little incentive for porters to become theatre assistants because there is no substantial difference in their respective pay scales. There is some evidence that domestics have entered auxiliary nursing (Jeffries) and there is surely potential in this area for upgrading in a more positive direction. It is reasonable to assume that some domestics have the potential to become SENs. In view of the fact that SENs are considered to be the craft workers in the nursing hierarchy, there is surely potential for attracting female and even male ancillaries into this particular occupation.[67]

If the resources for staff development were available, some thought could be given to providing a basic module for all ancillary workers, which would enlarge their perception of hospital work and arouse expectations which could be canalised into work that is richer in terms of knowledge and skill. This would, of course,

necessitate breaking down some of the barriers which have been set up to protect the status and territorial boundaries in the occupationa structure of hospitals.

If we translate the Halmos[68] case about upgrading the skills of all hospital ancillaries into practical terms, we come up against a number of real difficulties. It is quite evident that there is no pressing need to upgrade the skills of all ancillaries. There has always been an abundance of unskilled workers to work as domestics, porters and other ancillaries. These workers can be regarded as secondary underclass workers in hospitals. It is also reasonable to argue that these workers have been acquiescent in accepting their modest roles in the hospital service. They have not displayed the aspirations that ambulance workers and theatre workers have expressed about improving their occupational status.

Theoretically, it is possible to pool all the manpower resources of aides and ancillaries, and provide them with a basic training which would enable them to be much more flexible and adaptable. For instance, auxiliary nurses and domestics could share a basic training which would enable them to be much more flexible and interchangeable in the wards. In practice domestics, auxiliary nurses and even the SENs 'muck in' and help each other in critical situations. But, there might be a tremendous amount of controversy if such arrangements became formalised.

Lines of demarcation between porters and domestics could be broken down. In some hospitals, porters will accept responsibility for certain duties which are undertaken by domestics in others.

The division between these two occupational groups has traditionally been divided on sexist lines rather than upon genuine occupational requirements. Whilst porters have been regarded as workers who have to accept heavy manual duties, much of their work as receptionists and on other light duties, is less physically demanding than work traditionally undertaken by domestics.

There are also lines of demarcation between domestics and maintenance workers. In some hospitals, a domestic will not clean walls beyond a particular height because this is a maintenance task. In other hospitals, domestics will only accept responsibility for cleaning certain areas of an operating theatre, whilst nurses or theatre assistants are responsible for cleaning other areas.

Some ancillaries, such as the theatre assistants and ambulance workers, seem more anxious than porters or domestics to raise their occupationa status. Yet one should appreciate that any efforts to upgrade the skills of one or more of the ancillary groups could raise their expectations and aspirations in the other groups.

Most ancillary workers, particularly the males, have deep-seated grievances about their economic rewards and status. The NIBP 169 Report indicated that the ancillaries represent a low paid group of workers in a labour intensive service and it is evident that ancillary workers will endeavour to improve their position through adopting a more militant stance than they did in the period prior to 1973. The increase in number of strikes and other industrial sanctions in the last decade, reflects changes in attitudes

and expectations.

There does not appear to be a strong interest in joint consultation as a form of worker participation in the hospital service and it is evident that much more interest is being taken in local bargaining. Whilst there are limits to the scope to bargain locally on wages, there is scope in other areas. The assumption that joint consultation within the Whitley system will reflect the consensual concern about common interests relating to patient care has not been shared by ancillary workers. The increasing interest in local bargaining suggests that ancillary workers will follow industrial workers in exerting an incluence on mangerial authority and discretion.

This changing emphasis in attitudes towards industrial relations issues illustrates the nature of the changes taking place in the norms and values of the hospital sub-culture. It is reasonable to suggest that if professional leadership and values are not unifying the hospital workforce, then trade unionism, with its norms and values, is bringing ancillaries closer together. Whilst ancillaries might have pluralistic conflicts with medical, nursing and para-medical groups, all groups are showing an increasing interest in trade union objectives and strategies.

This study suggests that there is some scope for introducing measures which should improve relationships between theatre nurses and theatre assistants. Some of these measures could be introduced immediately; others might well have to be long term objectives. First, let us consider the immediate measures which could be taken.

The practices that have been recognised by theatre nurses and theatre assistants would be encouraged to continue if they provide the type of work relationships between these groups that were envisaged in the Lewin Report. These situations provide opportunities for theatre assistants to have flexible arrangements where they can either support the anaesthetist or the surgeon. Particular attention needs to be paid to the immediate measures to be taken to improve the selection of theatre assistants. In view of the many reservations that nurses have expressed about the calibre of the theatre assistants, every effort should be taken to improve the quality of the candidates for such positions. New appointments should possess basic GCE O-level qualifications in the appropriate subjects, or have equivalent qualifications as mature age applicants. These qualifications should ensure that they would benefit from the training demanded in the City and Guilds Course. In the case of mature age applicants, consideration could be given to providing men and women who have demonstrated that they possess the personal qualities for this work, with a basic course of a preliminary nature at a district or regional basis.

We also need to recognise the point raised by Hickey[69] that there is "no point in recruiting potentially good theatre assistants if they cannot be held". It is also worth noting that she attributed this loss to the low financial rewards which went to trained theatre assistants.

When theatre assistant trainees are being selected, they should be made aware of the difficulties they could encounter during and

after their training, about the problems that exist in the relationships between theatre nurses and theatre assistants, to prepare them in a realistic way for their role.

The long-term solution might be one of reconciling the conflicting interests between theatre assistants and theatre nurses through a number of positive steps. First, there is a need for providing reasonable financial rewards for nurses and assistants. Secondly, there is a good case for providing some measure of common training for both nurses and assistants. At present they pursue different forms of training and the fact that assistants are designated as ancillaries does not help in this respect. If the theatre assistants accept the advice of the Job Evaluation Panel to join the Royal College of Nurses, or become members of the Whitley Staff Council for Nurses and Midwives, this might tend to promote a common bond between the groups. If some form of agreement can be made between both groups it might only be possible in a milieu which provides opportunities for both groups to extend their role. This might mean that theatre nurses should have the same degree of training as the theatre assistants and this would mean updating their technical expertise and extending their role. Dummer[70] made the point, "One change that must come is the amalgamation of the theatre nurse and the operating department assistant. Bearing in mind the chronic shortage of theatre staff, it is obvious that we should be starting now to break down the barriers".

What is happening in the operating department in this country and in others is that operating departments are becoming highly

sophisticated and consequently run at a high cost. To work in these departments might well mean an upgrading of skills of the non professionals and the theatre nurses. It is, however, possible that the extension of the role of the nurses and assistants might well make some inroads into the well established areas of the medical professional groups.

It is also worth considering the need for changes in the way in which operating departments are organised. Hickey[71] argues that there is a case for a theatre manger who is responsible for all non medical personnel. Such an arrangement would be an improvement upon the present position where theatre assistants are responsible to an administrative had and a nursing head. Theatre assistants should have clearly defined roles, supported by job descriptions. They should be accountable to the nursing officer in charge of theatres for their theatre work. This nursing officer should have a close liaison with the head porter or unit administrator who is responsible for the contractual aspects of the theatre assistants because they are ancillary workers.

Consideration should also be given to the introduction of theatre users' committees which would include representatives of all sections of the workforce who use the theatre. This committee would involve the theatre assistants and bring them into closer contact with the various users of the theatre. It would also involve them in exercising some degree of influence over the decisions that have a direct bearing upon their work.

Hickey[72] has outlined the various industrial relations problems

which senior nurse theatre managers have to contend with which relate to all sections of the workforce and in particular the ancillaries. Hickey[73] made this point, "Increasingly the theatre manager must deal with union matters". She then dealt with the various problems which she had to contend with, which indicate the need for theatre managers to establish closer links with theatre assistants, theatre porters and theatre nurses, to resolve the various industrial relations problems that emerge in the theatre.

It is interesting to note that the Area Health Authority which covered for the Dulwich Hospital where the dispute about manning the operating theatres occurred in 1977, set up a special committee to resolve the various problems that arose in the operating departments in the hospitals in this area. An analysis of the report of this committee indicated that special efforts were being made to improve working relationships between theatre assistants and the medical and nursing groups in the theatre. This committee recommended the introduction of hospital theatre committees to deal with managerial and industrial type problems. Provision was also made that in the event of the committee being "unable to resolve a 'festering' problem, it could be referred to the Area Management Team".

J. C. Taylor[74], a senior nursing officer, has challenged the existing organisational structure ofr operating departments. This officer has argued that "The operating department/specialist unit is undoubtedly one of the most complex areas of the hospital - certainly labour intensive and functionally expensive, with manpower accounting for a high proportion of its overall budget". Taylor

argued that all operating departments should comprise one functional unit within a district and that such an arrangement would be much more efficient and offer more scope for developing theatre staff. Whilst this nursing officer recognises the need to bring theatre assistants and theatre nurses closer, no specific solutions were offered.

The concept of a district theatre complex might certainly disturb those who would want to retain control of the theatre within the hospital, but it offers certain advantages in providing a standardised manpower plan for theatre personnel under the control of a theatre coordinator. This type of organisational structure might provide the most suitable work milieu for realising the potential of theatre assistants and theatre nurses. Dummer[75] argued that

> The operating department of tomorrow will be increasingly scientific and technical. It is uneconomic to run separate courses for nurses and ODAs; not only uneconomic but unnecessary when in the long term each should be able to do the other's job. If all the staff working in the theatre had the same training and experience it would be easier to be flexible with the rosters, put an end to the dissension between nursing and ancillary staff and give a good career structure and equal opportunities to all. There could be a completely new training school for two years duration.

Dummer[76] is arguing for a new occupation. The suggestion of a two year period of training might not be acceptable to the nurses who now, as SRNs, receive three years. This suggestion might not be acceptable to the theatre assistants who are conscious of the point made by the Job Evaluation Panel that their course consists of only 300 hours of theoretical training.

Those who have studied the struggle of the personal service professionals are aware of the struggles that the early physicians had to become established and how they had to contend with the high status medical practitioners to establish a firm place in the medical profession. Stein[77] and Abel Smith[78] have also shown how nurses had to struggle for recognition and how they often came into conflict with the medical groups. Willcocks[79] has also referred to the conflicts between the medical group and other professional groups during the creation of the National Health Service. He also warned about the tensions that might emerge with the proliferation of professional and occupational groups within the service.

The conflict between the theatre assistants and the nurses is a conflict which demonstrates that the Halmos hypotheses concerning the commitment to tutelage and support among the established personal service professionals has not been substantiated in my particular study of the theatre assistants. The evidence that I have drawn from other sources tends to confirm my conclusions in respect of the hypothesis. The issues that Halmos raised in his work are, however, of considerable importance. There is a crucial need to make the best use of the manpower resources in the caring occupations. There should be opportunities to upgrade the skills of all who participate in operating departments. It might well mean that in order to enable one occupational group to enhance its status, there might well be repercussions on other groups.

Consideration should be given to expanding the role of the

nurses in operating departments. Dummer[80], a senior theatre nurse, sees an extended role for the nurse in anaesthetics and refers to the work in this area by nurses in Sweden and in the USA. She sees the developments in science and technology demanding a far wider range of skills and expertise in the theatre of the future. This suggests that there must be a realistic appraisal of how theatre personnel can be most effectively employed in the future.

There is also a need to consider the changing role of the ambulance workers. It is interesting to consider the progress that ambulance workers have made over the last decade. In 1984, there has been a significant change in the recruitment pattern. Applicants for the service in South Glamorgan now need to have at least four GCE O-level subjects and should convince the interviewing panel that they have the potential to acquire the para-medical type skills that the Association of Emergency Service Technicians set as the standard for members who wish to be accepted. It is worth noting that within the South Glamorgan Ambulance Service, five graduates have been recruited between 1983 and 1984.

Whilst ambulance workers tend to compare themselves with the policemen and firemen when negotiating their wage and salary claims, they are clearly part of the caring service. There is, however, a need to consider the extent to which there should be two tiers in the ambulance service. There is a growing body of opinion in the ambulance service that there is a need to retain one section of the workforce to provide a transport service conveying patients to and from the hospitals and clinics and another

section to concentrate on the para-medical type role with ambulance workers being fully trained to deal with emergency cases demanding medical care. This type of role exists in many States in the USA and some European countries.

The opponents of such a change argue that it would create an elitist structure in the ambulance service and would create tension in the workforce and undermine the solidaristic ties that have bound ambulance workers together in the militant action they have taken on contractual issues. This concern has been expressed by the trade unions which represent ambulance workers. The argument is countered by those who see a break as being inevitable if ambulance workers are to play their full part in the caring service.

It is evident that both groups are needed and it is reasonable to argue that both groups need to be trained for their respective roles. Those who are mainly concerned with conveying patients to hospitals and clinics should be trained for their technical tasks and also for empathising with patients. Those who specialise in emergency work should receive a broader type of training which would be in line with the type of training recommended in the Lewin Report of 1970, or on the lines recommended by the Emergency Service Technicians' Association.

Summary

It is evident from my findings that ancillaries have an important part to play in the NHS and much more consideration

should be given to cultivating the manpower resources of this section of the workforce in the interests of patients. But we also need to recognise that each of the ancillary groups has its own occupational characteristics, training needs and aspirations. We can appreciate that, whilst theatre assistants and ambulance workers have stronger intrinsic aspirations than domestics, porters and craftsmen, workers in all these occupations can experience some degree of intrinsic involvement in their work. Whilst there might be a limit to the extent to which they might respond to job enrichment and job enlargement schemes proposed by Williams *et al.*[81], there is a need to encourage ancillaries by improving their economic and occupational status. There is a need, too, to bring their wages much closer to the average earnings of other manual workers.

Much more consideration needs to be given to involving ancillaries far more in the caring work team of the ward, operating department, or other caring unit, to cultivate a clearer occupational identity. We are still a long way from changing the status of hospital ancillaries so that they will no longer be what Smith[82] describes as the "forgotten sector".

APPENDIX A ADDITIONAL TABLES

Table A1 The Relationship between self realisation expressed by ancillary workers and the degree to which they are involved with medical and nursing groups

a. Ambulance workers
b. Theatre Assistants
c. Porters
d. Domestics

Table A2 The Ancillary workers' perception of the degree to which they are appreciated by medical and nursing groups and the degree to which they expressed self realisation in their work

a. Ambulance workers
b. Theatre Assistants
c. Porters
d. Domestics

Table A3 Intrinsic involvement in work related to occupation

Table A4 Intrinsic involvement in work related to age group

Table A5 Role strain in work related to occupation

Table A6 Role strain in work related to age group

Table A7 The relationship between intrinsic involvement in work and nursing support

Table A8

a. Measuring the three values of personal service orientation
b. The expression of the three values of personal service orientation by occupational groups
c. The expression of personal service orientation by Theatre Assistants in three types of hospitals
d. The expression of personal service orientation related to occupation, age, group and sex

Table A9 Wage and walary rates and earnings for manual and non-manual workers in the NHS

Table A10 Industrial disputes in the NHS

TABLE A 1 a

THE RELATIONSHIP BETWEEN SELF REALISATION EXPRESSED BY ANCILLARY WORKERS AND THE DEGREE TO WHICH THEY ARE INVOLVED WITH MEDICAL AND NURSING GROUPS IN THEIR WORK

AMBULANCE WORKERS N 26

THE DEGREE OF PROFESSIONAL INVOLVEMENT

	HIGH	MEDIUM/LOW	ROW TOTAL	ROW PERCENTAGE
THE DEGREE OF SELF REALISATION				
HIGH				
n	2	10	12	54.5
ROW %	17	83		
COLUMN %	66	53		
GRAND TOTAL %	9	45		
MEDIUM/LOW				
n	1	9	10	45.5
ROW %	10	90		
COLUMN %	33	47		
GRAND TOTAL %	5	41		
COLUMN TOTALS	3	19	22	
COLUMN %	13.6	86.4		100

X = 0.26 C = 0.7 Not significant at 0.05 level for d f 1

TABLE A 1 b

THE RELATIONSHIP BETWEEN SELF REALISATION EXPRESSED BY ANCILLARY WORKERS AND THE DEGREE TO WHICH THEY ARE INVOLVED WITH MEDICAL AND NURSING GROUPS IN THEIR WORK

THEATRE ASSISTANTS N 45

	THE DEGREE OF PROFESSIONAL INVOLVEMENT			
THE DEGREE OF SELF REALISATION	HIGH	MEDIUM/LOW	ROW TOTAL	ROW PERCENTAGE
HIGH				
n	10	12	22	50
ROW %	45	55		
COLUMN %	52	48		
GRAND TOTAL %	23	27		
MEDIUM/LOW				
n	9	13	22	50
ROW %	41	59		
COLUMN %	48	52		
GRAND TOTAL %	21	30		
COLUMN TOTALS	19	25	44	
COLUMN %	43	57		100

$X^2 = 1$ C = 0.5 Not significant at 0.05 level for d f 1

TABLE A 1 c

THE RELATIONSHIP BETWEEN SELF REALISATION EXPRESSED BY ANCILLARY WORKERS AND THE DEGREE TO WHICH THEY ARE INVOLVED WITH MEDICAL AND NURSING GROUPS IN THEIR WORK

PORTERS N 39

THE DEGREE OF PROFESSIONAL INVOLVEMENT

	HIGH	MEDIUM/LOW	ROW TOTAL	ROW PERCENTAGE
THE DEGREE OF SELF REALISATION				
HIGH				
n	6	7	13	41
ROW %	46	54		
COLUMN %	50	35		
GRAND TOTAL %	19	22		
MEDIUM/LOW				
n	6	13	19	59
ROW %	32	68		
COLUMN %	50	65		
GRAND TOTAL %	19	41		
COLUMN TOTALS	12	20	32	
COLUMN %	37.5	62.5		100

$X^2 = 0.71$ C = 0.15 Not significant at 0.05 level for d f 1

TABLE A 1 d

THE RELATIONSHIP BETWEEN SELF REALISATION EXPRESSED BY ANCILLARY WORKERS AND THE DEGREE TO WHICH THEY ARE INVOLVED WITH MEDICAL AND NURSING GROUPS IN THEIR WORK

DOMESTICS N 50

	THE DEGREE OF PROFESSIONAL INVOLVEMENT			
	HIGH	MEDIUM/LOW	ROW TOTAL	ROW PERCENTAGE
THE DEGREE OF SELF REALISATION				
HIGH				
n	0	4	4	25
ROW %	0	100		
COLUMN %	0	27		
GRAND TOTAL %	0	25		
MEDIUM/LOW				
n	1	11	12	75
ROW %	8	92		
COLUMN %	100	73		
GRAND TOTAL %	6	69		
COLUMN TOTALS	1	15	16	
COLUMN %	6	94		100

$x^2 = 0.36$ C = 0.15 Not significant at 0.05 level for d f 1

TABLE A 2 a

THE ANCILLARY WORKERS' PERCEPTION OF THE DEGREE TO WHICH THEY ARE APPRECIATED BY MEDICAL AND NURSING GROUPS AND THE DEGREE OF SELF REALISATION THEY EXPRESS IN THEIR WORK

AMBULANCE WORKERS N 26

	PERCEPTION OF APPRECIATION			
	HIGH	MEDIUM/LOW	ROW TOTAL	ROW PERCENTAGE
DEGREE OF SELF REALISATION				
HIGH				
n	6	6	12	46
ROW %	50	50		
COLUMN %	55	40		
GRAND TOTAL %	23	23		
MEDIUM/LOW				
n	5	9	14	54
ROW %	36	64		
COLUMN %	45	60		
GRAND TOTAL %	19	35		
COLUMN TOTALS	11	15	26	
COLUMN %	42	58		100

$X^2 = 0.41$ C = 0.124 Not significant at 0.05 level for d f 1

TABLE A 2 b

THE ANCILLARY WORKERS' PERCEPTION OF THE DEGREE TO WHICH THEY ARE APPRECIATED BY MEDICAL AND NURSING GROUPS AND THE DEGREE OF SELF REALISATION THEY EXPRESS IN THEIR WORK

THEATRE ASSISTANTS N 45

	PERCEPTION OF APPRECIATION			
	HIGH	MEDIUM/LOW	ROW TOTAL	ROW PERCENTAGE
DEGREE OF SELF REALISATION				
HIGH				
n	12	8	20	46.5
ROW %	60	40		
COLUMN %	50	42		
GRAND TOTAL %	28	25.4		
MEDIUM/LOW				
n	12	11	11	53.5
ROW %	52	48		
COLUMN %	50	58		
GRAND TOTAL %	28	25.4		
COLUMN TOTALS	24	19	43	
COLUMN %	55.8	44.2		100

$X^2 = 0.29$ C = 0.08 Not significant at 0.05 for d f 1

TABLE A 2 C

THE ANCILLARY WORKERS' PERCEPTION OF THE DEGREE TO WHICH THEY ARE APPRECIATED BY MEDICAL AND NURSING GROUPS AND THE DEGREE OF SELF REALISATION THEY EXPRESS IN THEIR WORK

PORTERS N 39

	PERCEPTION OF APPRECIATION			
	HIGH	MEDIUM/LOW	ROW TOTAL	ROW PERCENTAGE
DEGREE OF SELF REALISATION				
HIGH				
n	6	6	12	31.6
ROW %	50	50		
COLUMN %	50	23		
GRAND TOTAL %	16			
MEDIUM/LOW				
n	6	20	26	68.4
ROW %	23	77		
COLUMN %	50	77		
GRAND TOTAL %	16	52		
COLUMN TOTALS	12	26	38	
COLUMN %	31.5	68.4		100

$X^2 = 2.7$ C = 0.07 Not significant at 0.05 for d f 1

TABLE A 2 D

THE ANCILLARY WORKERS' PERCEPTION OF THE DEGREE TO WHICH THEY ARE APPRECIATED BY MEDICAL AND NURSING GROUPS AND THE DEGREE OF SELF REALISATION THEY EXPRESS IN THEIR WORK

DOMESTICS N 50

	PERCEPTION OF APPRECIATION			
	HIGH	MEDIUM/LOW	ROW TOTAL	ROW PERCENTAGE
DEGREE OF SELF REALISATION				
HIGH				
n	1	8	9	39
ROW %	11	89		
COLUMN %	20	44		
GRAND TOTAL %				
MEDIUM/LOW				
n	4	10	14	61
ROW %	29	71		
COLUMN %	80	56		
GRAND TOTAL %	16	43		
COLUMN TOTALS	5	18	23	
COLUMN %	22			

$X^2 = 3.87$ C = 0.32 Significant at 0.05 for d f 1

TABLE A 3

INTRINSIC INVOLVEMENT IN WORK

Analysis of variance for occupational groups

Sum of squares between groups

Ambulance	Theatre	Porters	Domestics	Draft	All
2	2	2	2	2	2
296	462	449	551	227	1985
24	39	35	39	16	153

25886.9 - 25753 = 133.9

Sum of squares within groups

Ambulance	3748 - 3650	= 98
Theatre	3612 - 5472	= 140
Porters	6019 - 5760	= 259
Domestics	7951 - 7784	= 167
Craftsmen	3268 - 3220	= 48

Sources of Variation	Degrees of Freedom	Sum of Sq	Mean Sq
Between groups	4	133.9	33.5
Within groups	149	712	4.78

F = 33.5

4.78 = 7 Not significant at 0.05

TABLE A 4

INTRINSIC INVOLVEMENT IN WORK

Analysis of variance for three age groups

Sum of Squares between groups

UNDER 30		30 to 40		40 and over		all
$\frac{641^2}{49}$	+	$\frac{472^2}{37}$	+	$\frac{865^2}{67}$	-	$\frac{1985^2}{153}$
8285.3		6201.1		11167.5		
				25753.8	-	25753
Sum of squares within groups						0.7

Under 30	8637	- 8325	=	252
30 to 40	6338	- 6201	=	137
40 & over	11623	- 11167	=	456
				845

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square
Between groups	2	0.7	0.35
Within groups	149	845	5.65

$F = \frac{0.35}{5.67} = 0.06$ Not significant at 0.05

TABLE A 5

ROLE STRAIN : OCCUPATIONAL GROUPS

Analysis of variance for five occupational groups

Sum of squares between groups

Ambulance	Theatre	Porters	Domestics	Craftsmen		All
$\frac{231^2}{26}$	$\frac{309^2}{37}$	$\frac{280^2}{33}$	$\frac{229^2}{31}$	$\frac{93^2}{13}$	=	$\frac{1141^2}{140}$
2052	2550	2375	1691	651 = 9349		9299.15

Sum of Squares 9349 - 9299.15 = 49.85

Within Groups

Ambulance	2182 - 2052	=	128
Theatre	2780 - 2580	=	200
Porters	2422 - 2375	=	47
Domestics	1743 - 1691	=	52
Craftsmen	674 - 651	=	23
All			450

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square
Between groups	4	49.85	12.46
Within groups	136	450	3.31

$$F = \frac{12.46}{3.31} = 3.76$$

Not significant at 0.05

TABLE 6

ROLE STRAIN - AGE GROUPS

Analysis of variance for three age groups

Sum of squares between groups

Under 30		30 to 40		40 and over			
$\frac{427^2}{51}$	+	$\frac{269^2}{33}$	+	$\frac{445^2}{56}$	-	$\frac{1141^2}{140}$	
3575	+	2192	+	3536.16	-	9299.15	
				9303.16	-	9299.15	= 4.01

Within groups

Under 30	3769	- 3575	=	194
30 to 40	2271	- 2192	=	79
40+	3759	- 3536	=	223
				496

Source of variation	Degree of Freedom	Sum of squares	Mean square
Between groups	2	4.01	2.01
Within groups	136	496	3.65

$$F = \frac{2.01}{3.65} = 0.55$$

Not significant at 0.05

TABLE A 7

THE RELATIONSHIP BETWEEN THE EXPRESSION OF INTRINSIC INVOLVEMENT IN WORK AND THE DEGREE OF NURSING SUPPORT

The Degree of intrinsic involvement in work

THE DEGREE OF NURSING SUPPORT	THE DEGREE OF INTRINSIC INVOLVEMENT IN WORK Percentaging to overall grand total as base			
	HIGH	MEDIUM	LOW	ALL
HIGH	8.62% N = 10*	18.97% N = 22	3.45% N = 4	31.04% N = 36
MEDIUM	4.31% N = 5	52.59% N = 61	5.17% N = 6	62.07% N = 73
LOW	1.72% N = 2	1.72% N = 2	2.59% N = 3	6.03% N = 7
	14.65% N = 17	73.28% N = 85	11.21% N = 13	99.14% N = 116

$X^2 = 18.5$ C = 0.37 Significant at 0.01 for d f 4

* Of this 10, 5 were theatre assistants. This five represented 15.15% of the 33 theatre assistants who responded to the relevant questions.

TABLE A 8 a

MEASURING THE THREE VALUES OF PERSONAL SERVICE ORIENTATION

The First Value : Intrinsic involvement	Question Number	Scale Range High	Low
The Components			
1. Meaningful work (responses to question)	17	1	3
2. Intrinsic satisfaction "	10	3	6
3. Self realisation "	26 & 27	2	6
4. Workplace participation "	29 & 30	2	6
The Second Value : Concerned empathy			
The Components			
1. Wanting to know patients (responses to question)	21	1	3
2. Knowing patients can be stressful "	22	1	3
The Third Value : Occupational Integrity			
The Components			
1. Encouraged to help patients by nurses (responses to question)	14	1	3
2. Get on well with nurses "	16	1	3
3. Nurse appreciation "	12	2	6
4. Nurse awareness of work "	26	1	3
5. Role conflict with nurses "	25	2	6

Highest possible score 16

Lowest possible score 45

Degree of personal service orientation score

High	16 to 26
Medium	27 to 38
Low	39 to 48

TABLE A 8 b

THE DEGREE OF PERSONAL SERVICE ORIENTATION EXPRESSED BY FIVE OCCUPATIONAL GROUPS OF ANCILLARY WORKERS

THE THREE VALUES OF PERSONAL SERVICE ORIENTATION AND THEIR COMPONENTS
(Weighted mean averages)

The First Value Intrinsic involvement	THE OCCUPATIONAL GROUPS					
	Ambulance	Theatre	Porters	Domestics	Craftsmen	All
The Components	n = 26	n = 45	n = 39	n = 50	n = 21	n = 181
Meaningful work	1.09	1.13	1.34	1.43	2	1.34
Intrinsic satisfaction	3.8	3.8	4.4	5.4	5.5	4.49
Self realisation	3.2	2.7	2.9	2.8	2.9	2.88
Workplace participation	4.7	3.9	4.5	4.6	3.8	4.26
	12.79	11.53	12.9	14.23	14.2	12.97
The Second Value Concerned empathy						
The Components						
Like to know patients	2.23	2.8	2.53	2.76	2.82	2.63
Knowing patients stressful	2.04	2.29	1.91	2.08	2.38	2.14
	4.63	5.09	4.56	5.84	5.30	4.47
The Third Value Occupational Integrity						
The Components						
Encouraged by nurses	1.08	1.35	107	2.46	2.31	1.07
Get on well with nurses	1.78	1.72	1.72	1.07	2.21	1.71
Nurses appreciate our work	2.83	2.61	2.61	3.18	2.86	2.88
Nurse awareness of work	2.15	2.31	2.13	2.02	2.03	2.13
Role conflict with nurses	2.65	2.05	2.05	1.92	1.08	2.23
	11.21	9.86	11.1	11.28	10.76	10.65
Sum of mean scores	28.27	27.08	28.46	29.95	30.01	28.37

Analysis of variance for occupation based on the responses of 109 ancillaries
F = 1.59 for d f 4 and 105, not significant at 0.05

Analysis of variance for age groups based on the responses of 109 ancillaries
F = 2.73 for d f 4 and 105, not significant at 0.05.

TABLE A 8 c

THE THREE VALUES OF PERSONAL SERVICE ORIENTATION EXPRESSED BY THEATRE ASSISTANTS IN THREE TYPES OF HOSPITAL

The three values and their components	Type of Hospital			
	Large (Teaching) (n = 19)	Medium (n = 11)	Other Hospitals (n = 15)	All Hospitals (n = 45)
First Value: (Intrinsic Involvement)				
The Components				
Meaningful work	1.22	1.09	1.07	1.13
Intrinsic satisfaction	3.9	3.27	3.47	3.8
Self realisation	2.6	2.64	2.7	2.7
Workplace participation	2.28	3.9	4.7	3.9
Second Value: (Concerned Empathy)				
The Components				
Like to know patients	2.81	2.08	2.08	2.08
Knowing patients stressful	2.29	2.01	2.05	2.03
Third Value: (Occupational Integrity)				
The Components				
Encouraged by nurses	1.4	1.09	1.57	1.35
Get on well with nurses	2.06	1.45	1.64	1.72
Nurses appreciate work	3.06	2.27	2.5	2.61
Nurses aware of work	2.0	1.9	2.14	2.13
Role conflict with nurses	3.56	3.45	3.45	2.05
Total score	28.28	26.15	28.01	27.08

Analysis of Variance for the three groups $F=1.7$ for d f 25 and 2

Not significant at 0.05

TABLE A 8 d

THE EXPRESSION OF PERSONAL SERVICE ORIENTATION RELATED TO OCCUPATION, AGE AND SEX

Occupation : Analysis of Variance
Between sum of squares

	Ambulance	Theatre	Porters	Domestics	Craft	All
Between Sum of squares	$\frac{700^2}{24}$	$\frac{630^2}{23}$	$\frac{795^2}{28}$	$\frac{835^2}{28}$	$\frac{150^2}{5}$	$\frac{3110^2}{108}$

10416.7 + 17256.5 + 22572 + 14900.8 + 4500 - 89556.5

89646 - 89556.5

Within sum of squares = 89.5

20656 - 20416.7
17613 - 17256.5
23173 - 22572
25227 - 24900.8
4518 - 4500

91187 - 89646 = 1541

Sources of variation	d f	Sum of squares	Mean square
Between groups	4	89.5	22.38
Within groups	103	1541	14.96

F = 1.5 Not significant for d f 4 and 103 at 0.05

Age: Analysis of variance

	Under 30	30 - 40	40+	All
Between Sum of squares	$\frac{1095^2}{37}$	$\frac{793^2}{27}$	$\frac{1220^2}{44}$	$\frac{3110^2}{108}$

32406 + 23290 + 33938 89556.5

89634 - 89556.5

Within sum of squares = 78.5

33060 - 32406
23485 - 23290
34642 - 33938.3

91187 - 89635 = 1552

Sources of variation	d f	Sum of squares	Mean square
Between groups	2	78.5	39.25
Within groups	105	1552	14.78

F = 2.66 Not significant for d f 2 and 105 at 0.05

Sex: Analysis of variance

	Male	Female	All
Between Sum of squares	$\frac{2031^2}{72}$	$\frac{1079^2}{36}$	$\frac{3110^2}{}$

57291 + 32340 - 89556.5

89631 - 89556.5

Within sum of squares = 74.5

58253 - 57291
32934 - 32341

91187 89632 = 1555

Sources of variation	d f	Sum of squares	Mean square
Between groups	1	74.5	74.5
Within groups	107	1555	14.53

F = 5.13 Not significant for d f 1 and 107 at 0.05

TABLE A 9

FULL TIME MEN, AGED 21 AND OVER, WHOSE PAY WAS NOT AFFECTED BY ABSENCE

GREAT BRITAIN April, 1981

National Agreement in the Public Sector National Health Service	M-Manual N-Non-Manual	Average Gross Weekly Earnings Total	of which Over-time Pay	Payment by results etc. Pay	Shift etc Premium Pay	Average hourly earnings excl. overtime
Administrative & clerical Staffs		£	£	£	£	Pence
Whitley Council	N	(155.3)	2.7	0.5	1.2	410.5
Nurses and midwives						
Whitley Council	N	127.4	5.2	0.1	12.8	326.1
Ancillary Staffs						
Whitley Council	M/N	99.3	14.7	6.9	8.7	211.8
Maintenance Staff	M	(126.5)	16.3	18.6	2.9	276.0
Ambulancemen:						
Whitley Council	M	(128.4)	19.6	7.6	11.9	271.4

FULL-TIME WOMEN, AGED 18 AND OVER, WHOSE PAY WAS NOT AFFECTED BY ABSENCE

GREAT BRITAIN April, 1981

Administrative & clerical Staffs						
Whitley Council	N	88.5	0.6	0.3	0.2	239.4
Nurses and midwives						
Whitley Council	N	99.7	0.9	0.1	9.0	265.4
Ancillary Staffs						
Whitley Council	M/N	75.8	3.1	4.9	6.4	137.6

( ) Brackets denote that the standard of error of the average earnings is relatively high (between 2 and 4 percent) and these figures should be used with caution.

TABLE A 10

COMPARISON OF DAYS LOST THROUGH STRIKE ACTION IN THE NHS WITH THE WORKFORCE AS A WHOLE : GREAT BRITAIN 1966 - 1977

Year	Number of NHS Staff	Number of Stoppages	Number of Staff involved	Number of days lost	Average number of days lost per 1,000 NHS staff	Average no of days lost per 1,000 employees in Great Britain
1966	728,838	2	500	500	0.69	100.0
1867	753,486	1	78	200	0.27	124.7
1968	761,747	1	80	80	0.11	211.4
1969	778,998	8	2,500	7,000	8.99	309.1
1970	792,307	5	1,300	6,700	8.46	499.2
1971	799,673	6	2,900	4,700	5.88	625.9
1972	831,753	4	97,000	98,000	117.8	1,104.3
1973	843,119	18	59,000	298,000	353.5	324.4
1974	859,468	18	4,070	23,000	26.84	661.5
1975	914,068	19	6,000	20,000	21.88	270.6
1976	945,877	15	4,440	15,000	15.86	149.3
1977	970,900	21	2,970	8,200	8.44	448.0

Source: Compiled from statistics provided by health departments and the Department of Employment

APPENDIX B

Notes on Statistical Method

1. The statistical data in this study has been drawn from a sample of 232 hospital ancillary workers, of this total 181 ancillaries fell into 5 homogenous occupational groups.

2. The coefficient of reproducibility based on the Cornell technique for 11 questions embracing 33 items relating to personal service orientation was 0.80.

3. A reproduction score of 89 from the responses of 25 ancillaries who responded to the questionnaire on two occasions within an interval of 14 days was obtained.

4. The tabulated data were placed into contingency tables, with occupations grouped in columns and responses to questions in rows.

5. Where possible the data in the tables have been subjected to a chi square test to establish the degree of significance and also the contingency coefficient test to establish the degree of association between the tabulated variables such as occupational group and particular attitudes.

6. Whilst most of the data was presented in the form of percentages based on column totals the chi square test and the contingency coefficient test related to the raw data.

7. It should be noted that if contigency tables have more than 2 columns the chi square test may be used if fewer than 20% of the cells have an expected frequency of less than 5 and if no cell has an expected frequency of less than 1. If these requirements are not met it is recommended that suitable combined categories be formed to meaningfully apply the chi square test.*

8. Most of the tables needed no adjustment. For instance, most of the tables had columns that referred to occupational groups, and rows which were grouped on the basis of high, medium or low involvement. In the event of the cells not being suitable for the chi square test then adjustments were made to form two rows. One row would refer to high involvement responses whilst the other two would combine medium and low involvement.

9. Analysis of variance tests were also applied to the responses of ancillaries to establish the significance of the mean average scores for intrinsic involvement in work, for role strain and for the three values of personal service orientation.

10. The method of determining the scores for all questions that were subjected to chi square and analysis of variance tests were placed in three categories. A score of 1 would be given for a favourable response to a question, a score of 2 for a moderate or medium response and a score of 3 for a low or unfavourable response.

11. Percentages in most of the tables have been based on column totals but some have included row total percentages, based on the overall average or grand mean.

* See S. Siegel, Non Parametric Statistics for the Behavioural Sciences, McGraw Hill 1956

APPENDIX C

The Questionnaire

1. AGE

20 - 30	☐
30 - 40	☐
40 - 50	☐
50 - 60	☐
Over 60	☐

2. MALE ☐
   FEMALE ☐

3. HOSPITAL WHERE YOU WORK:-

Heath	☐
St. David's	☐
Royal Infirmary	☐
Sully	☐
Llandough	☐
Lansdowne	☐
Rhydlafar	☐
Other	☐

4. WHAT IS YOUR OCCUPATION?

Porter	☐
Theatre Technician	☐
Ambulance Driver	☐
Domestic	☐
Ward Orderly	☐
Laundry Worker	☐
Catering Worker	☐
Building Craftsman	☐
Engineering Craftsman	☐
Other	☐

5. HOW DID YOU OBTAIN YOUR JOB?

- Reply to Advertisement
- Employment Exchange
- Advised by Relative
- Advised by Friend
- Advised by Trade Union
- Other

6. INDICATE, IN ORDER OF IMPORTANCE, WHICH OF THE FOLLOWING CONSIDERATIONS INFLUENCED YOU MOST TO TAKE UP YOUR HOSPITAL JOB.

- A Secure Job
- Job near Home
- Job where I can help people
- An Interesting Job
- Other

7. ARE YOU SATISFIED WITH YOUR CHOICE OF JOB?

- Very Satisfied
- Reasonably Satisfied
- Dissatisfied
- Very Dissatisfied

8. ARE YOU SATISFIED WITH YOUR JOB PROSPECTS IN YOUR JOB?

- Very Satisfied
- Reasonably Satisfied
- Dissatisfied
- Very Dissatisfied

9. WHAT DO YOU CONSIDER TO BE THE MOST SATISFYING ASPECT OF YOUR JOB? INDICATE IN ORDER OF IMPORTANCE

- Helping People in Need
- People you meet are interesting
- The tasks in the job are interesting
- Good working conditions
- Good companions
- A Secure Job
- Good Pay
- Other

10. DOES YOUR JOB BRING YOU INTO PERSONAL CONTACT WITH THE STAFF OF THE DEPARTMENTS LISTED BELOW :-

	Every Day	Once a Week	Occasionally	Never
Consultants				
Other Doctors				
Medical Labs.				
Catering				
Laundry				
Porters				
Kitchen Staff				
Domestic				
Ambulance Men				
Others				

11. HOW WELL DO YOU GET ON WITH THE FOLLOWING?

	Very Well	Fairly Well	Not Well
Consultants			
Other Doctors			
Medical Labs.			
Catering			
Laundry			
Porters			
Kitchen Staff			
Domestic			
Ambulance Men			
Others			

12. DO YOU FEEL THAT YOUR WORK FOR THE PATIENT IS APPRECIATED BY THE STAFF LISTED BELOW :-

	Yes	No	Don't Know
SENIOR NURSES (SISTERS & ABOVE)			
OTHER NURSING STAFF			
CONSULTANTS			
OTHER DOCTORS			

13. ARE YOU ENCOURAGED BY NURSING STAFF TO TALK TO PATIENTS?

Often	
Occasionally	
Never	

14. ARE YOU ENCOURAGED BY NURSING STAFF TO HELP PATIENTS?

Often	
Occasionally	
Never	

15. DOES YOUR WORK BRING YOU INTO PERSONAL CONTACT WITH NURSING STAFF?

Every Day	
About once a week	
Occasionally	
Never	

16. DO YOU GET ON WELL WITH NURSING STAFF?

I get on well with all	
I get on well with most	
I get on well with some	
Not well	
I have no contact with them	

17. DO YOU THINK THAT YOU ARE DIRECTLY HELPING THE PATIENT THROUGH YOUR WORK?

- Often
- Sometimes
- Rarely
- Not at all
- No contact

18. IF YOU HAVE NO DIRECT CONTACT WITH PATIENTS DO YOU THINK THAT YOU HELP THEM INDIRECTLY?

- Often
- Sometimes
- Rarely
- Not at all

19. CAN YOU GIVE AN EXAMPLE OF SOME OF THE WAYS IN WHICH YOU CAN HELP A PATIENT. IF SOME OF THE EXAMPLES BELOW APPLY, PLEASE RING THEM.

- Running a message for them
- Chatting to them
- Helping them to walk
- General Favours
- Others

20. DO YOU THINK THAT YOU COULD DO MORE FOR THE PATIENT IN YOUR JOB?

- A great deal more
- Somewhat more
- Not much more

21. WOULD YOU LIKE TO KNOW THE PATIENTS AS INDIVIDUALS?

- I know most of them
- I would like to know more of them
- Not really
- Not relevant to my job

22. DO YOU THINK THAT YOU DON'T WANT TO KNOW THE PATIENTS TOO WELL BECAUSE IT MIGHT BE STRESSFUL?

I would like to know them well

I don't want to be involved

I would like to know them casually

23. MARY JONES, A WARD DOMESTIC, WAS TALKING TO A PATIENT, WHO LIVED IN HER NEIGHBOURHOOD, ABOUT FAMILY PROBLEMS. A STAFF NURSE ON DUTY OVERHEARD HER CONVERSATION AND TOLD MARY TO CARRY ON WITH HER DUTIES. WHICH OF THE FOLLOWING OUTCOMES TO THIS EPISODE DO YOU THINK WAS MOST LIKELY TO HAPPEN?

Mary carried on talking because she thought she was helping the patient

Mary felt guilty about neglecting her duties and walked quickly away

Mary said to the staff nurse, 'Don't be so fussy.'

24. ARE YOU SATISFIED THAT NURSING STAFF ARE AWARE OF YOUR DUTIES?

Very Satisfied

Satisfied

Dissatisfied

Very Dissatisfied

25. DO YOU EXPERIENCE CONFLICTING DEMANDS UPON YOU?

Between nurses and patients -

Often

Occasionally

Never

Between nurses and my supervisor -

Often

Occasionally

Never

26. HOW IMPORTANT IS YOUR WORK?

- I am extremely interested in it
- I am reasonably interested in it
- I have very little interest in it
- I have no interest in it

27. DO YOU THINK THAT YOUR ABILITIES AND INTEREST ARE FULLY USED IN YOUR WORK?

- Very much so
- To some extent
- Not very much

28. DO YOU THINK THAT YOUR WORK PROBLEMS ARE APPRECIATED BY :-

- Your Supervisor
- Your fellow worker

29. DOES YOUR SUPERVISOR SEEK YOUR ADVICE ON WORK MATTERS?

- Regularly
- Occasionally
- Never

30. DO YOU THINK THAT YOU ARE HELPING TO MAKE DECISIONS THAT RELATE TO YOUR WORK?

- A great deal
- Somewhat
- Not at all
- Don't know

31. DO YOU BELONG TO A TRADE UNION?

- Not a member
- N.U.P.E.
- C.O.H.S.E.
- T.G.W.U.
- G.M.W.U.
- U.C.A.T.T.
- N.A.L.G.O.
- E.P.T.U.
- Other

32. IT HAS BEEN STATED THAT HOSPITAL WORKERS SHOULD NEVER STRIKE. WHAT DO YOU THINK?

The strike should never be used	
Strikes, at times, can be justified	
Other sanctions are more appropriate	
No difference between strikes in hospital and elsewhere	

33. DO YOU AGREE WITH THE FOLLOWING STATEMENTS?

Ambulance workers who went on strike worried about its effect upon the patients.

Agree	
Disagree	
Don't know	

Coal miners who went on strike worried about its effect upon hospitals.

Agree	
Disagree	
Don't know	

APPENDIX D

SUMMARIES OF MAIN DUTIES OF DOMESTICS WORKING IN HOSPITAL WARDS. FROM ORGANISATION AND MANAGEMENT OF DOMESTIC WORK - HOSPITAL ORGANISATION AND METHOD SERVICE: REPORT 4

SWEEPING FLOORS, ETC.

Floors
Stairs

POLISHING FLOORS

Applying polish
Buff floor

WASHING AND SCRUBBING FLOORS, ETC

Washing floors
Scrubbing floors
Scrubbing stairs
Cleaning walls

DUSTING AND POLISHING FURNITURE, ETC.

Damp dusting, by hand
Polishing by hand

WASHING UP CROCKERY, ETC.

Washing up by hand
Sorting and packing crockery into grids prior to washing

CLEANING STAFF BEDROOMS, ETC. (HOUSEHOLD SERVICES)

CLEANING OFFICES

CLEANING TOILETS, BATHROOMS AND SLUICES

Cleaning washbasin and taps
Polishing taps

CLEANING WINDOWS

Clean and polish with cloth
Wash down with soft brush (for outside of windows)

APPENDIX E

PROPOSED TRAINING SYLLABUS FOR HOSPITAL PORTERS

A. Module I - Lifting and Transportation

Lifting and carrying objects
Lifting and carrying human beings
Transportation of equipment and vehicles
Practical care, maintenance and safety checks of trucks
Safe handling, transportation of gas cylinders
Speedy transportation, erection and dismantling of medical equipment
Handling and disposal of refuse
Transportation of dirty and clean linen

Module II - Safety and Controls

Control of noise
Prevention of fire
Speedy responsible action in case of fire
Operation of lifts and action in emergencies
Effective control of traffic in accordance with hospital policy
Life support system

Module III - Communications and Human Relations

Recognition of uniforms
Verbal and written communications
Understanding people and dealing with confidential information
Skills of communication
Function of bleep
Identification of callers
Dealing with suspicious people or drunken fights
Giving clear directions *

SYLLABUS FOR A DIPLOMA IN PORTERING MANAGEMENT

B.

Organisation of the NHS
General Principle of Management
Management of Personnel
Management of Resources
Legal Aspects

* South Glamorgan Area Health Authority Training Service

** Recommended by National Association of Head Porters, 1974

APPENDIX F

City and Guilds Course 752

Hospital Operating Department Assistants

AIMS

1. General

a) To have a knowledge of hospital organisation and the inter-relationship of the various departments and services.
b) To have a knowledge of basic medical ethics and an understanding of the medico-legal implications of hospital work.
c) To have skill in care of the patient, inter-personal relationships, communication and teamwork.
d) To be alert to safety aspects of work in the operating department.

2. Anaesthetics

a) To understand and carry out routine preparation of an anaesthetic room.
b) To understand and carry out preparation and maintenance of anaesthetic and resuscitation equipment and the care of drugs for anaesthesia. To implement agreed safety measures in the anaesthetic room. To understand and carry out resuscitation methods, including emergency techniques.
c) To understand common methods of inducing and maintaining anaesthesia and analgesia.
d) To understand basic science relevant to the storage and handling of gases and anesthetic apparatus.
e) To be able to receive and identify patients and to check documents relating to the proposed operation.
f) To assist in blood transfusions, intravenous infusions and intravascular procedures.
g) To life, move and position patients in the operating department.

3. Surgery

a) To understand and carry out aseptic techniques, methods of bacterial control and methods of sterilisation and decontamination.
b) To understand and carry out the preparation and cleaning of theatre equipment and furniture.
c) To understand the basic science relevant to the working of autoclaves and to the care of surgical instruments, equipment and materials.
d) To be able to operate autoclaves safely and have a working knowledge of the methods used by theatre sterile supplies units and/or central sterile supplies departments.
e) To understand the structure, function and monitoring of the main systems of the body in relation to surgical operations.
f) To be able to prepare splints and traction apparatus and undertake orthopaedic plaster work under medical guidance.

g) To be able to perform the duties of circulating and 'scrubbed' assistant in the operating team, including swab and instrument counts.
h) To understand and apply the metric system of measurement.
i) To assist with the care, labelling and despatch of specimens for laboratory examination.
j) To identify, handle, store and assist in checking drugs and lotions used in the theatres.
k) To know how to order stores and supplies.

APPENDIX G

EXTRACT FROM BRITISH JOURNAL OF ANAESTHESIA 1976 - 48 377

Table - The value to the patient of a mobil resuscitation unit

Nature of	Journey Definitely valuable (1)	Possibly valuable (2)	Survival in (1) and (2) to leave hospital	Hospital deaths	Life saved Definitely	possibly
Road accidents	7(17%)	6(15%)	13 (100%)	0	1 (3%)	1 (3%)
Other accidents	6 (28%)	4 (19%)	9 (9%)	1 (10%)	0	1 (10%)
Heart disease	30 (64%)	10 (21%)	34 (85%)	6 (15%)	2 (5%)	12 (30%)
Overdose	3 (19%)	4 (25%)	7 (87%)	0	0	0
Respiratory dis.	5 (55%)	0	3 (60%)	2 (40%)	2 (22%)	1 (11%)
Other medical	4 (20%)	5 (20%)	9 (100%)	0	0	3 (33%)
Other surgical	4 (66%)	1 (16%)	4 (80%)	1 (20%)	1 (20%)	0
Patient dead	4 (36%)	3 (27%)		7 (100%)		
Totals	63 (37%)	33 (19%)	79 (82%)	17 (10%)	6 (3.5%)	18 (11%)

Table - The need for a doctor and nurse

Nature of case	Hospital doctor present	G.P. Present	Doctor needed	Nurse present
Road accident	24 (60%)	0	3 (7%)	3 (7%)
Other accident	9 (43%)	0	4 (19%)	2 (9%)
Heart disease	19 (40%)	5 (12%)	16 (34%)	5 (11%)
Overdose	5 (31%)	2 (12%)	0	1 (6%)
Respiratory disease	4 (44%)	0	2 (22%)	2 (22%)
Other medical	8 (40%)	3 (15%)	1 (5%)	0
Other surgical	2 (33%)	1 (16%)	2 (33%)	0
Patient dead	4 (36%)	4 (36%)	3 (27%)	0
Totals	75 (44%)	15 (9%)	31 (18%)	13 (8%)

Notes and References

Introduction and Chapter One.

1 P. Halmos, The Personal Service Society, Constable, 1970, pp. 10 - 11

2 ibid. pp. 22

3 ibid. pp. 162-163

4 ibid. pp. 161-163

5 ibid. pp. 23-26

6 ibid. pp. 161-162

7 F. Herzberg, The Motivation to Work, Wiley, 1959, pp. 107-119

8 A.H. Maslow, A Theory of Human Motivation, Psychological Review, Vol. 50, 1943, pp. 370-396

9 P. Halmos, op cit, pp 169-161

10 ibid. p. 160

11 ibid. pp. 73, 166-167

12 ibid. pp. 152-153

13 J. Goldthorpe, D.Lockwood, F. Bechover and J. Platt, The Affluent Worker, Cambridge University Press, 1968, pp. 10-42

14 P. Halmos, op cit, pp. 155-166

15 ibid. pp. 155-166

16 ibid. pp. 155-166

17 ibid. p. 235

18 ibid. p. 166

19 ibid. p. 122

20 ibid. pp. 23-25

21 ibid. pp. 21-23

22 ibid. pp. 145-198

23 ibid. pp. 181-187

24 ibid. pp. 181-187

25 E. Georgopoulos and F. Mann, The Community General Hospital, New York, McMillan, 1962, pp. 5-15

26 ibid. pp. 1-15

27 ibid. pp. 1-15

28 P. Halmos, op cit, pp. 160-166

29 ibid. pp. 160-166

30 E. Georgopoulos and F. Mann, op cit, pp. 5-15

31 W.Waitzkin and B. Waterman, The Exploitation of Illness in Capitalist Society, Bob Merril Studies in Sociology, 1974, pp. 60-69

32 A.J. Willcocks, The Creation of the National Health Service, Routledge Kegan Paul, 1965, pp. 29-36

33 E. Georgopoulos and F. Mann, op cit, pp. 5-15

34 P. Halmos, op cit, pp. 160-164

35 ibid. pp. 172 - 173

36 A. Strauss, The Hospital and its Negotiated Order, The Hospital in Modern Society, Edited by E. Friedson, McMillan, 1963, pp. 146 - 166

37 ibid. pp. 146 - 166

38 ibid. pp. 146 - 166

39 P. Halmos, op cit, p. 191

40 A.J. Willcocks, op cit, pp. 29 - 36

41 Wright Mills, White Collar, Oxford University Press, pp. 115 - 121

42 ibid. pp. 115 - 121

43 ibid. pp. 115 - 121

44 P. Halmos, op cit, pp. 181 - 192

45 ibid. pp. 57 - 58

46 ibid. pp. 181 - 192

47 ibid. pp. 16 - 62

48 ibid. pp. 176 - 190

49 ibid. p. 9

50 ibid. p. 190

51 ibid. p. 9

52 ibid. pp. 152 - 162

53 T. Shibutani, American Journal of Sociology. Vol 60, 1955, pp. 562 - 569

54 P. Halmos, op cit. pp. 56 - 57

55 J. Goldthorpe et al. op cit, p. 12

56 P. Halmos, op cit. pp. 161 - 162

57 ibid. pp. 161 - 162

58 ibid. pp. 161 - 167

59 ibid. p.9

60 ibid. pp. 166 - 167

61 ibid. p. 195

62 ibid. p. 11

63 ibid. pp. 145 - 153

64 A. Fox, A Sociology of Work in Industry, Collier McMillan, 1970, pp. 11-25

65 ibid. pp. 11 - 25

66 F. Herzberg, op cit. pp. 107 - 119

67 A.H. Maslow, op cit. pp. 370 - 396

68 F. Herzberg, op cit. pp. 107 - 119

69 A.H. Maslow, op cit. pp. 370 - 396

70 P. Halmos, op cit, pp 161 - 165

71 ibid pp 161 - 163

72 J. Goldthorpe et al, op cit, pp 39 - 42

73 ibid pp 38 - 39

74 ibid pp 38 - 39

75 ibid pp 39 - 40

76 ibid pp 39 - 40

77 ibid pp 36 - 39

78 ibid pp 39 - 40

79 ibid pp 42 - 43

80 ibid pp 174 - 186

81 ibid pp 174 - 186

82 F.Herzberg, op cit, pp 370 -

83 A.H. Maslow, op cit, pp 370 - 396

84 J.Woodward, Industrial Organisations, Oxford University Press, 1965 pp 36 - 37

85 J. Goldthorpe et al, op cit, pp 38 - 42

86 R. Brown, Sources of Objectives in Work from Man in the Organisation, Edited by J. Childs, Allen and Unwin, 1972, pp 17 - 38

87 W.W. Daniel, Understanding Employees Behaviour in its Context from Man in the Organisation, Edited by J. Childs, Allen and Unwin, 1972, pp 39 - 54

88 H.Beynon and R.Blackburn, Perceptions of Work, Cambridge University Press, 1972, pp 39 - 54

89 R. Brown, op cit, pp 150 -

90 W.W. Daniel, op cit, pp 39 - 54

91 J. Goldthorpe et al, op cit, pp 174 - 186

92 A. Fox, op cit, pp 15 - 25

93 ibid pp 15 - 25

94 P. Halmos, op cit, pp 166 - 167

95 A. Fox, op cit, pp 161 - 165

96 N.C.Morse and R.S.Weiss, The Function and Meaning of Work and the Job, American Sociological Review, Vol 20, 1955, pp 191 - 198

97 ibid pp 191 - 198

98 A. Fox, op cit, pp 15 - 24

99 N.C. Morse and R.S. Weiss, op cit, pp 191 - 198

100 D.C. Marsh and A.J.Willcocks, The Recruitment of Nurses, University of Nottingham Research Papers, 1961, pp 7 - 17

101 W.W. Daniel, op cit, pp 39 - 54

102 ibid pp 39 - 54

103 ibid pp 39 - 54

104 ibid pp 39 - 54

105 R.Dubin, Industrial Workers World, A Study of the Central Life Interests of Industrial Workers, Social Problems, Vol. 3, Jan 1966, pp 131 - 142

106 ibid pp 131 - 142

107 A. Fox, op cit, pp 11 -13

108 P. Halmos, op cit, p 180

109 R.H. Hall, Occupations and the Social Structure, Prentice Hall, 1969 pp 70 - 137

110 H.Wilensky, The Professionalisation of Everyone, The Sociology of Organisations, Edited by O. Grunsky and G.A. Millar, Free Press pf Glencoe, 1970 pp 117 - 166.

111 P. Halmos, op cit, p 179

112 Wright Mills, op cit,pp 111 - 115

113 W.S.Siebert, Occupational Licensing, British Journal of Industrial Relations, Vol. 15, No. 1 1977, pp 29 - 35.

114 R.M.Titmuss, Essays on the Welfare State, Unwin, 1958 pp 189 - 196

115 B.Sherlock and A.Cohen, The Strategy of Occupational Choice Recruitment for Dentistry, Social Forces, Vol 44, March 1966 pp 301 - 313.

116 E.Quinney, Adjustment to Occupational Role Strain, The Case of Retail Pharmacy, South Western Social Science Quarterly, March 1964 pp 361 - 376

117 I.H.Simpson, Patterns of Socialisation into Professions, The Case of the Student Nurse,Sociological Enquiry, No 7, Winter 1967, pp 47 - 54

118 A.T.Aitschul, Commitment to Nursing Journal of Advanced Nursing, Vol 4, 1979, pp 123-124.

119 E.A.Krause, The Sociology of Occupations, Little Brown and Co., 1968 pp 319 - 341

120 J.C.McGuire, Why Girls Go Into Nursing, Bell 1969 pp 37 - 45

121 D.C.Marsh and A.J. Willcocks, op cit, pp 7 - 17

122 H.J.Meyer, Issues on Social Work, Edited by A.J.Kahn, Columbia University Press pp 310 - 340

123 M.Carter, Into Work, Pelican, 1969, p 41 47, 141 - 142

124 P.Wilmot, Adolescent Boys of East London, Pelican, 1969 pp 106 - 125

125 A.M.Evans and W.D.Morgan, A Survey of Male Portering Staff in South Wales, Welsh Staff Advisory Body, 1964 pp 1 - 20

126 A.P.T.Williams, B.L.Levy, R.Silverstone, and P. Adams, The Recruitment and Retention of Hospital Ancillary Staff, City University Business School, 1977, pp 75 - 76

127 N.Coghill, Hospital Internal Communication Project, Report on West Middlesex Hospital, 1965 p 75.

128 J.Woodward, Employment Relations in a Group of Hospitals, Institute of Hospital Administrators, Publication, 1948, pp 36 - 37

129 N.Coghill, op cit p 19

130 J.Woodward, op cit p 54.

131 J. Goldthorpe, et al, op cit, pp 40-41

132 A.P.T. Williams, et al, op cit, pp 75-76

133 N. Jeffries, Appraisal of Labour Wastage in the Housekeeping Department of Cardiff Royal Infirmary, Dissertation Polytechnic of Wales, 1975, p.22

134 D.C. Marsh and Willcocks, op cit, P.19

135 J. Goldthorpe, et al, op cit, pp 38-39

136 A. Fox, op cit, pp 15-24

137 P. Halmos, op cit, pp 32-34

Chapter Two

1 P. Halmos, The Personal Service Society, Constable, 1970, pp 161-166

2 A.T. Aitschul, Commitment to Nursing, Advanced Journal of Nursing Studies, Vol. 1, No.4, pp 123-125

3 A. Strauss, L. Schatzman, D. Ehrlich, R. Bucher and M. Sabshin, The Hospital and its Negotiated Order, The Hospital in Society, Ed. by E.Friedson, 1963 pp 147-148

4 C. Burz, A Study of Role Strain, Dissertation University of Michigan 1970 pp 59-69

5 S. Hanschu, Profile of the Nurses Aide, Gereontologist, Oct. 1973, pp 315-317

6 M. Kramer, Nurse Role Deprivation, Social Science and Medicine, Vol.2, 1968 pp 461-463

7 J. McLoskey, The Influence of Rewards and Incentives on Staff Turnover Nursing Research, Vol.23, May-June 1974, pp 239-247

8 P. Halmos, op cit, pp 161-166

9 ibid pp 161-166

10 R. Blauner, Alienation and Freedom, University of Chicago, 1964, pp 27-28

11 G. Susman, Process Design Automation and Worker Alienation, Industrial Relations, Vol.11, Feb. 1972, pp 37-38

12 R. Blauner, op cit, pp 16-20, 42-43

13 G. Susman, op cit, p 37

14 P. Halmos, op cit, pp 161-166

15 ibid pp 165-166

16 L.I. Pearlin, Alienation from Work, A Study of Nursing Personnel, American Sociological Review, Vol. 17, 1962, pp 314-326

17 I. Traile, The Relationship of Role Conflict and Alienation, University of California Dissertation, 1971, pp 124-144

18 G. Hespe and T. Wall, Attitudes towards Participation and Satisfaction Among Nurses, in 'Worker Participation' ed. by T.Wall and J.A. Lischerson, McGraw Hill, 1977, pp 45-61

19 N. Coghill, Worker Participation and Worker Control, International Conference on Participation and Worker Control, Paris 1973.

20 P. Halmos, op cit, pp 161-166

21 ibid pp 161-166

22 E. Anderson, The Role of the Nurse, Royal College of Nursing, 1974 pp 41, 74

23 ibid pp 39-42

24 P. Halmos, op cit, p 161

25 E. Anderson, op cit, pp 39-45

26 P. Tomlin, Psychological Problems in Intensive Care, British Medical Journal Vol. No.2 August 1977, pp 441-443

27 L.M. Bramner, The Helping Relationship, Prentice Hall, 1979, pp 23-25

28 P. Tomlin, op cit, pp 441-443

29 L.M. Bramner, op cit, pp 23-25

30 ibid pp 23-25

31 L.I. Pearlin and M. Rosenburg, Nurse Patient Relationship, American Sociological Review, Vol.27, 1961, pp 56-57

32 J. Evans, Stratification and Alienation in the Hospital Setting, Ohio State University of Columbia, 1960, pp 50-65

33 ibid pp 50-65

34 R. Schmitt, Role Conflict in Nursing, Americal Journal of Nursing, Vol.68, 1968, pp 2348-2350

35 C. Burz, Role Strain, Dissertation University of Michigan, 1972, pp 51-69

36 P. Halmos, op cit, pp 166-167

37 ibid pp 166-167

38 L.M. Bramner, op cit, pp 23-25

39 ibid pp 38-39

40 ibid pp 38-39

41 ibid pp 38-39

42 M.M. Johnson and A.W. Martin, A Sociological Study of the Nurses Role, American Journal of Sociology, Vol.58, No.3, 1958, pp 373-377

43 E.A. Anderson, The Role of the Nurse, Royal College of Nursing, 1973, pp 73-74

44 ibid pp 66-67

45 P. Halmos,The Faith of the Counsellors, Constable, 1967, pp 49-175

46 R. Coser, Alienation and the Social Structure, The Hospital in Modern Society, Ed. by E. Friedson, New York Free Press, 1963, pp 251-265

47 P. Halmos, op cit, p 166

48 R. Coser, op cit, pp 236-265

49 ibid pp 231-265

50 P. Halmos, op cit, p 166

51 R. Schmitt, op cit, pp 2348-2350

52 A. Strauss, The Professions Work and Careers, Sociology Press, 1971, pp 69-78

53 D. Riessman, The Helper Theory Principal, Social Work, Vol.10, No.2, 1967 pp 87-95

54 P. Halmos, op cit, pp 55-56

55 E. Goffman, Asylums, Pelican, 1968, pp 294-333

56 G. Stannard, Old Folks and Dirty Work, Readings in the Sociology of Nursing, Ed. by R.Dinglewell and J.McIntosh, Churchill Livingstone, 1978, pp 164-180

57 P. Halmos, op cit, p 166

58 ibid, pp 166-167

59 E. Georgopoulos and Mann, The Community General Hospital, New York, McMillan, 1962, pp 5-15

60 R. Corwin, A Study of Role Conflict in Nursing Roles, American Sociological Review, Vol.66, 1961, pp 606-615

61 I. Traile, op cit, pp 124 - 144

62 R. Corwin, op cit, pp 606 - 615

63 I. Traile, op cit, pp 124 - 144

64 R. Kramer, op cit, pp 461 - 465

65 R. Corwin, op cit, pp 606 - 615

66 I. Traile, op cit, pp 124 - 144

67 M. Kramer, op cit, pp 461 - 475

68 D.C. Fieldman, Organisational Socialisation of Hospital Employees, Medical Care, Vol. 15, No.10, Oct. 1977, pp 799 - 811

69 R. Schmitt, op cit, pp 2348 - 2350

70 R. Corwin, op cit, pp 605 - 615

71 E. Anderson, op cit, pp 39 - 54

72 K. Williams, Ideologies of Nursing, Readings in the Sociology of Nursing, Ed. by R. Dinglewell and J. McIntosh, Churchill Livingstone, 1979, pp 36 - 37

73 P. Halmos, op cit, pp 161 - 166

74 R. Kahn, D. Wolfe, R. Quinn, J. Snoek and R. Rosenthal, Organisational Stress Wiley, New York, 1964, pp 49 - 71

75 E. Anderson, op cit, pp 64 - 71

76 P. Halmos, op cit, pp 161 - 166

77 J.W. Slocum, Jnr. G.I. Susman, and F.T. Sheridan, An Analysis of Need Satisfaction, and Job Performance Among Professional and Para-Professional Hospital Personnel, Nursing Research, Vol.21, No.4, pp 338 - 341

78 N.Carpenter, Managerialism and the Division of Labour in Nursing Readings in the Sociology of Nursing, Ed. by R. Dinglewell and J. McIntosh, Churchill Livingstone Press, 1979, pp 87 - 103

79 ibid pp 87 - 103

80 R. Corwin, op cit, pp 605 - 615

81 I. Traile, op cit, pp 124-144

82 C. Burz, op cit, pp 59 - 69, 71

83 R. Schmitt, op cit, pp 2348 - 2350

84 P. Halmos, op cit, pp 166 - 167

85 A.P.T. Williams, B. Levy, R. Silverstone and P. Adams, The Recruitment and Retention of Hospital Ancillary Staff, City University Business School, 1977, pp 75 - 76

86 A.J. Dale, Job Satisfaction, and Organisation Among Domestic Workers Industrial Relations, Vol. 3, No.10, 1965, pp 164 - 179

87 ibid pp 164 - 179

88 ibid pp 164 - 179

89 ibid pp 164 - 179

90 ibid pp 164 - 179

91 ibid pp 164 - 179

92 ibid pp 164- 179

93 K. Saunders, The Hospital Porter, Employee Relations, Vol.1, No.4, 1979, pp 31 - 32

94 ibid pp 31 - 32

95 ibid pp 31 - 32

96 ibid pp 31 - 32

97 G.Susman, op cit, 34 - 45

98 A.P.T. Williams et al, pp 131 - 132

99 ibid pp 131 - 132

100 K. Saunders, op cit, pp 31 - 32

101 P. Halmos, op cit, pp 161 - 163

102 A.P.T. Williams etal, op cit, p 130

103 K. Saunders, op cit, pp 30 - 31

104 P. Halmos, op cit, pp 161 - 163

105 R.Schmitt, op cit, pp 2348 - 2350

106 A.Strauss, op cit, pp 102 - 103

107 C.Burz, op cit, pp 59 - 69

108 S.S.Handschu, op cit, pp 315 - 319

109 C.Burz, op cit, pp 59 - 69

110 ibid pp 59 - 69

111 ibid pp 59 - 69

112 S.S.Handschu, op cit, pp 2348 - 2350

113 M.Johnson, Nursing Auxiliaries and Nurse Professionalism, Nursing Times Vol. 74, No.8, Feb 1878, pp 313 - 317

114 K.Saunders, op cit, pp 30 - 32

115 ibid pp 30 - 32

116 A.P.T. Williams et al, op cit, p 130

117 A.J. Dale, op cit, pp 164 - 179

118 P. Halmos, op cit, pp 164 - 167

119 R. Blauner, op cit, pp 26 - 28, 53 - 54, 174 - 175

120 W.A. Faunce, Problems in Industrial Society, McGraw Hill, 1968, pp 115 - 6, 126

121 J.Shepard, Alienation as a Social Process, Sociological Quarterly, Vol. 13, No.2, pp 161 - 172

122 W.A.Faunce, op cit, pp 115 - 116

123 P. Halmos, op cit, pp 176 - 177

124 T.Shibutani, Reference Groups as Social Control, Americal Journal of Sociology, Vol. 60, 1955, pp 569 - 662

125 P. Halmos, op cit, pp 197 - 198

126 C. Burz, op cit, pp 59 - 69

127 C.Stannard, Old Folks and Dirty Work in Readings in the Sociology of Nursing ed. by R.Dinglewell and J.McIntosh, Churchill Livingstone, 1978 pp 164 - 179

128 M. Johnson, op cit, pp 313 - 317

129 ibid pp 313 - 317

130 N. Coghill, op cit, pp 19 - 22

131 N.J.Jeffries, Appraisal of Labour Wastage, in the Housekeeping Department of Cardiff Royal Infirmary, Dissertation, Polytechnic of Wales, 1975, pp 26 - 44

132 K. Saunders, op cit, pp 30 - 32

133 A.P.T. Williams et al, pp 85 - 86

134 P. Halmos, op cit, pp 150 - 151

135 T. Shibutani, op cit, pp 562 - 569

136 W.A. Faunce, op cit, pp 115 - 121

137 P. Halmos, op cit, pp 115 - 121

138 ibid, pp 145 - 160

139 N. Coghill, op cit, pp 5 - 6, 19

140 A.J. Dale, op cit, pp 164 - 169

141 N. Jeffries, op cit, pp 21 - 22

142 K. Saunders, op cit, pp 30 - 32

143 A.P.T. Williams et al, op cit, pp 85 - 88

144 J. Woodward, Employment Relations in a Group of Hospitals, Hospital Administrators Publication, 1948, pp 36 - 37

145 P. Halmos, op cit, pp 161 - 165

146 ibid pp 116 - 167

147 ibid pp 166 - 167

148 ibid p 166

149 ibid pp 166 - 169

150 ibid pp 166 - 167

151 R. Blauner, op cit, pp 42 - 45

152 ibid pp 42 - 45

153 P. Halmos, op cit, pp 166 - 167

154 R. Blauner, op cit, pp 42 - 45

155 P. Halmos, op cit, pp 14

156 ibid pp 166 - 167

157 P. Tomlin, op cit, pp 441 - 443

158 E. Anderson, op cit, pp 72 - 77

159 P. Halmos, op cit, pp 166 - 172

160 L. Bramner, The Helping Relationship, Prentic Hall, 1978, pp 38 - 39

161 P. Halmos, op cit, p 166

162 ibid p 166

163 ibid pp 53, 166 - 169

164 ibid p 195

165 ibid pp 57, 147 - 148, 194 - 195

166 ibid pp 56, 184 - 194

167 W.L. Faunce, op. cit., pp. 115 - 215.

168 J. Shepard, op. cit., pp. 161 - 173.

169 T. Shibutani, op. cit., pp.

170 W.L. Faunce, pp. 115 - 125.

171 C. Burz, op. cit., pp. 69 - 71.

172 S.S. Handschu, op. cit., 315 - 317.

173 K. Saunders, op. cit., pp. 31 - 32.

174 A.P.T. Williams et al., op. cit., pp. 87 - 88.

175 P. Halmos, op. cit., pp. 160 - 166, 169, 172, 184.

176 F. Riessman, The Helper Therapy Principal, Social Work, Vol. 10, No. 2, 1965, pp. 87 - 95.

177 P. Halmos, op. cit., pp. 16 - 17, 182 - 183.

178 ibid., p. 155.

179 ibid., pp. 161 - 167.

180 F. Riessman, op. cit., pp. 87 - 95.

181 P. Halmos, op. cit., pp. 161 - 167.

Chapter Three

1 P. Halmos, The Personal Service Society, Constable, 1970, pp. 147 - 149.

2 A. Strauss, L. L. Schatsman, D. Ehrlich, M. Sabshin, The Hospital and Its Negotiated Order, The Hospital and Society, ed. by E. Friedson, McMillan 1963, pp. 147 - 169.

3 P. Halmos, op. cit., pp. 161 - 162.

4 ibid., pp. 161 - 162.

5 R. Blauner, Alienation and Freedom, University of Chicago Press, 1964, pp. 26 - 28.

6 J. Goldthorpe, D. Lockwood, F. Bechover and J. Platt, The Affluent Worker, Cambridge University Press, 1968, pp. 10 - 42, 116 - 143, 144 - 173.

7 D.T. Marsh and A.J. Willcocks, The Recruitment of Nurses, University of Nottingham Research Paper, 1961, pp. 7 - 17.

8 N. Coghill, Hospital Communication Project, West Middlesex Hospital, 1965, pp. 3 - 7.

9 A.J. Dale, Job Satisfaction and Organisation Among Domestic Workers, British Journal of Industrial Relations, Vol. 3, No. 1, pp. 164 - 169.

10 P. Halmos, op. cit., p. 161.

11 R. Blauner, op. cit., pp. 15 - 32.

12 H. Beynon and R. Blackburn, Perception of Work, Cambridge University Press, 1972, pp. 161 - 163.

13 P. Halmos, op. cit., pp. 161 - 163.

14 P. Halmos, op. cit., pp. 56 - 57.

15 H. Beynon and R. Blackburn, op. cit., pp. 161 - 163.

16 P. Halmos, op. cit.,

17 L.M. Bramner, The Helping Relationship, Prentice Hall, 1979, pp. 23 - 25.

18 P. Halmos, op. cit., pp. 166 - 167.

19 ibid., pp. 161 - 163.

20 ibid., pp. 161 - 163.

21 ibid., pp. 166 - 167.

22 ibid., pp. 160 - 167.

23 ibid., pp. 167 - 169.

Chapter Four

1 P. Halmos, The Personal Service Society, Constable, 1970, pp. 162 - 163.

2 T. Shibutani, Reference Groups and Social Control, American Journal of Sociology, Vol. 60, 1955, pp. 562 - 569.

3 P. Halmos, op. cit., pp. 170 - 178, 198.

4 ibid., p. 172 - 181.

5 R. Cooper, Job Motivation and Job Design, Institute of Personnel Management Publication, 1974, p. 62.

6 G. McInnes, Gown and Glove, Journal of New Zealand Theatre Nurses, A Time to Care, Vol. 3, No. 4, Spring 1978, p. 10.

7 P. Halmos, op. cit., p. 162.

8 ibid., p. 162.

9 ibid., p. 166.

10 ibid., p. 166.

11 ibid., p. 11.

12 ibid., pp. 56 - 57.

13 C. Burz, University of Michigan: Dissertation, 1972, pp. 59 - 69.

14 P. Halmos, op. cit., pp. 56 - 57, 180 - 181.

15 ibid., p. 198.

16 ibid., p. 56 - 57.

Chapter Five

1 P. Halmos, The Personal Service Society, 1970, pp.

2 ibid., pp. 166 - 167.

3 G.R. Grace, Role Conflict and the Teacher, Routledge Kegan Paul, 1972, pp. 1 - 12.

4 R. Burz, A Study of Role Strain, University of Michigan: Dissertation pp. 59 - 69.

5 R.L. Kahn, D. Wolf, R. Quinn and J. Snoek, Organisational Stress, Wiley, 1964, pp. 49 - 71.

6 ibid., pp. 49 - 70.

7 ibid., pp. 49 - 70.

8 A. Strauss, The Professions, Work and Careers. Sociology Press, 1971, pp. 229 - 237.

9 A. Evans and W.D. Morgan, A Survey of Portering Staff in South Wales, Welsh Staff Advisory Body, 1964, pp. 1 - 24.

10 D. Smith, The Forgotten Sector, Pergammon Press, 1969.

11 A.M. Evans and W.D. Morgan, op.cit., pp. 1 - 24.

12 D. Smith, op. cit., pp. 83 - 101.

13 N. Jeffries, Appraisal of Labour Wastage in the Housekeeping Department of Cardiff Royal Infirmary, Polytechnic of Wales: Dissertation, 1975, pp. 15 - 27.

14 Mrs. J. Mortimer,*

15 E. Anderson, The Role of the Nurse, Royal College of Nursing, 1973, pp. 73 - 74.

16 R. Coser, Alienation and the Social Structure, The Hospital in Modern Society, ed. by E. Friedson, New York Free Press, 1963, pp. 231 - 265.

17 M.L. Johnson and A.W. Martin, A Sociological Study of Nurses Role, American Journal of Nursing, Vol. 58, No. 3, 1961, pp. 131 - 137.

18 E. Anderson, op. cit., pp. 73 - 77.

19 J. Evans, Stratification and Alienation in the Hospital Setting, Ohio State University, Columbia, 1964, pp. 50 - 73, 74 - 79.

20 D. Robinson, Patients Practitioners and Medical Care, Heinamann, 1973, pp. 52 - 63.

21 J. Evans, op. cit., pp. 50 - 73, 74 - 79.

22 D. Robinson, op. cit., pp. 65 - 74.

23 S.C. Haywood, Managing the Health Service, Allen and Unwin, 1974, p.177.

24 E. Anderson, op. cit., pp. 53 - 57, 76 - 77.

25 J.A. Roth, The Treatment of Tuberculosis as a Bargaining Process in Human Behaviou and Social Processes, ed. by A.M. Rose, Routledge Kegan Paul, 1962, pp. 575 - 578.

26 ibid., pp. 575 - 578.

27 E. Anderson, op. cit., pp. 72 - 79.

28 M.L. Johnson and A.W. Martin, op. cit., pp. 373 - 377.

29 R. Burz, op. cit., pp. 59 - 69.

30 S. Handschu, Profile of the Nurses Aide, Gereontologist, October 1973, pp. 315 - 317.

31 A. Strauss, pp. 69 - 78.

32 P. Tomlin, Psychological Problems in Intensive Care, British Medical Journal, August, 1977, No. 2, pp. 441 - 443.

33 M.L. Johnson and A.W. Martin, op. cit., pp. 131 - 136.

34 ibid., pp. 131 - 136.

35 F. Davies and V. Olenson, Initiating into a Women's Profession, Sociometry, 26th March, 1963, pp. 89 - 101.

36 P. Halmos, Faith of the Counsellors, Constable, 1966, pp. 49 - 74.

37 ibid., pp. 118 - 119.

38 ibid., p. 146.

39 ibid., p. 146.

40 E. Anderson, op. cit., p. 107.

41 P. Halmos, op. cit.,

42 M.L. Johnson and A.L. Martin, op. cit., pp. 373 - 377.

43 A. Strauss, op. cit., pp. 69 - 78.

44 ibid., pp. 69 - 78.

45 M.L. Johnson and A.L. Martin, op. cit., pp. 373 - 377.

46 A. Blum, Differential Use of Manpower in Public Welfare, Social Work, Vol. 11, No. 1, 1966, pp. 16 - 21.

47 W. Richar, A Theoretical Scheme for Determining Roles of Professional and Non Professionals, Social Work, Vol. 6, No. 4, pp. 22 - 28.

48 A. Blum, op. cit., pp. 16 - 21.

49 R.R. Carkhuaff and C.B. Truax, Lay Mental Health Counselling, Journal of Consulting Psychology, Vol. 29, No. 5, 1965, pp. 426 - 431.

50 A. Strauss, op. cit., pp. 69 - 78.

51 F. Riessman, Gap Strategies and Suggestions for Training Non Professionals, Community Health Journal, Vol. 3, No. 2, 1967, pp. 103 - 110.

52 A. Strauss, op. cit., pp. 69 - 78.

53 E. Anderson, op. cit., pp. 72 - 79.

54 C. Burz, op. cit., pp. 59 - 69.

55 J. Evans, op. cit., pp. 50 - 79.

56 F. Riessman, op. cit., pp. 103 - 110.

57 P. Tomlin, op. cit., pp. 441 - 443.

58 P. Halmos, op. cit.,

59 ibid., pp. 166, 172.

60 ibid., pp. 166, 172.

61 ibid., pp. 22 - 24.

62 ibid., pp. 56 - 57.

63 E. Anderson, op. cit., pp. 72 - 77.

64 S. Handschu, op. cit., pp. 315 - 317.

65 S.C. Hayward, op. cit., 179 - 181.

66 A. Strauss, op. cit., pp. 69 - 78.

67 P. Halmos, pp. 171 - 172, 194.

68 ibid., p. 11.

69 ibid., pp. 11, 57.

Chapter Six

1 P. Halmos, The Personal Service Society, Constable, 1972, pp. 146, 194.

2 A.M. Carr Saunders and P. Wilson, The Professions, Oxford University Press, 1933, p. 33.

3 E. Greenwood, Attributes of a Profession, Social Work, Vol. 2, July 1957, pp. 45 - 55.

4 S. Green, The Hospital as an Organisation, Black, 1974, pp. 68 - 69.

5 ibid., pp. 68 - 69.

6 Correspondence in Technic Journal of the British Association of Operating Department Assistants, February 1973, September 1979, January 1983.

7 H.S. Becker and J. Carper, The Elements of Identification within an Occupational Group, American Sociological Review, Vol. 23, 1956, pp. 341 - 346.

8 H. Wilensky, The Professionalisation of Everyone, The Sociology of Organisations, ed. by O. Grunsky and G.A. Millar, Free Press of Glencoe, 1970, pp. 137 - 158.

9 ibid., pp. 137 - 158.

10 Correspondence in Technic, February 1973.

11 M.M. Williams, Theatre of Protest, Nursing Mirror, 1979, Vol. 148, No. 11, pp. 20 - 22.

12 W.J.T. McArthy, Making Whitley Work, D.H.S.S. Publication, 1975, pp. 68 - 75.

13 A. Strauss, The Hospital and its Negotiated Order, The Hospital in Modern Society, ed. by E. Friedson, McMillan, 1968 pp. 147 - 166.

14 The Lewin Report, 1970

15 Working Party on The Development of Nurses' Education, The Development of Nurses Education Working Group 3 Consultation Paper 1, 1982 by U.K. Central Council for Nursing Midwifery and Health Visiting.

16 G. Esland, Professions and Professionalism in the Politics of Work and Occupations, ed. by G. Esland and G. Salamon, Open University Press, 1980, p.241.

17 G. Esland, ibid,. pp. 239 - 250.

18 Lewin Report, 1970.

19 The Millar Report, Working Party on Ambulance Training and Equipment 1966

20 P. Baskett, The Value to the Patient of a Mobile Resuscitation Unit, British Journal of Anaesthesis Urban Mobile Resuscitation, 1976, No. 48, pp. 370 - 377.

21 H. Beynon and R. Blackburn, Perceptions of Work, Cambridge University Press, 1979, pp. 161 - 163.

22 G. Gibson, 1931, History of Mental Hospitals and Institutions, Express Co-operative Printing Society.

23 Hospital Health Service Review, August 1974.

24 J. Sugden, Hospital Health Service Review, May 1975.

25 Editorial Health Service Review, February 1979.

26 R.K. Dyson, The Ancillary Staff Industrial Actions in the Spring 1973, Yorkshire Area Health Authority.

27 P.F. Seccord and W.R. Backman, Social Psychology, McGraw Hill, 1967, pp. 421 - 458.

28 W.T. McArthy, op. cit., pp. 68 - 75, 88 - 96.

29 ibid., pp. 68 - 75, 88 - 96.

30 R.K. Dyson, op. cit.,

31 V. Navarro, Medicine Under Capitalism, Crown Helm New York, 1977, pp. 279 - 237.

32 H.B. Waitzkin and B. Waterman, The The Exploitation of Illness in Capitalist Societies, Bob Meril Studies in Sociology, 1974, pp. 65 - 86.

33 R.M. Titmuss, Essays on the Welfare State, Unwin, 1968, p. 162.

34 The Briggs Report, Report of the Committee on Nursing, 1972.

35 National Board of Prices and Incomes, Report 166, April 1971.

36 L. Salaman, Class at the Corporation, Fontana Books, 1981, pp. 106 - 112.

37 H. Beynon and R. Blackman, op. cit., pp. 61 - 87.

38 A.P.T. Williams, et al.,

39 S.C. Haywood, Managing the Health Service, Allen and Unwin, 1974, p. 161.

40 P. Halmos, op. cit., p. 162 - 164.

41 Royal Commission on the N.H.S., 1979.

42 A.J. Willcocks, The Creation of the N.H.S., Routledge Kegan Paul, 1965, pp. 13 -36.

43 C. Bishop, Hospital from Primary to Secondary, Labour Market Industrial Relations Review, Vol. XVI, No. 1, 1972, pp. 26 - 34

44 R. Hyman, Strikes, 1970, Fontana Books, 1972, pp. 70, 103.

45 A.P.T. Williams, et al., The Recruitment and Relation of Hospital Ancillary Staff, City Univeristy Business School, 1977, pp. 89 - 94.

46 A.P.T. Williasm, ibid., pp. 89 - 94.

47 N. Jeffries, Appraisal of Labour Wastage in the Housekeeping Department of Cardiff Royal Infirmary, Dissertation, Polytechnic of Wales, 1974, pp. 6 - 12.

48 A.P.T. Williams, et al., pp. 35 - 36, 53.

49 N. Jeffries, op. cit., pp. 28 - 33, 172.

50 N. Jeffries, ibid., pp. 28 - 33, 172.

51 A.P.T. Williams, B. Levy, H. Silverstone and P. Adams, The Recruitment and Retention of Hospital Ancillary Staff, City University Business Schoo, pp. 89 - 94.

52 Office of Health Economics, Publication 'Off Sick', January 1971.

53 A.P.T. Williams, op. cit.,

54 N. Jeffries, op. cit.,

55 L. Rice, Labour Turnover in a Hospital, University of Wales Science Technology, Dissertation 1979, pp. 1 - 10.

Chapter Seven

1 P. Halmos, The Personal Service Society, Constable, 1970, pp. 161 - 165.

2 ibid., p. 11

3 ibid., pp. 160 - 165.

4 ibid., pp. 161 - 165.

5 ibid., pp

6 R. Blauner, Alienation and Freedom, University Press of Chicago, 1964, pp. 27 - 29.

7 ibid., pp. 27 - 29.

8 W. Faunce, Problems of an Industrial Society, McGraw Hill, 1968, pp. 115 - 125.

9 J. Shepard, Alienation as a Social Process, Sociological Quarterly, Vol. 13, pp. 161 - 173.

10 P. Halmos, op. cit., pp. 161 - 166.

11 R. Blauner, op. cit., pp. 27 - 28.

12 ibid., pp. 27 - 28.

13 G. Hespe and T.D. Wall, Attitudes Towards Participation and Satisfaction Among Nurses in Worker Participation, ed., by T.D. Wall and J.A. Lischerson McGraw Hill, 1977, pp. 45 - 61.

14 P. Halmos, op. cit., pp. 166 - 167.

15 ibid., p. 166.

16 R. Blauner, op. cit., pp. 27 - 29.

17 P. Halmos, op. cit., pp

18 E. Anderson, The Role of the Nurse, Royal College of Nursing, 1973, pp. 72 - 74.

19 E.L. Brown, Nursing and Patiert Care, ed., by J.A. Davies, Wiley 1966, p. 196

20 P. Halmos, pp. 161 - 166.

21 ibid., pp. 166 - 167.

22 ibid., pp. 166 - 168.

23 H. Wilensky, Work as a Social Problem,Work and Leisure, Free Press, Glencoe, 1964, pp. 117 - 166.

24 J. Shepard, op. cit., pp. 163 - 173

25 ibid., pp. 163 - 173.

26 ibid., pp. 153 - 173.

27 P. Halmos, op. cit., pp. 166 - 167.

28 ibid., pp. 166 - 168.

29 ibid., pp. 154, 174 - 179.

30 ibid., pp. 11, 154, 174 - 179.

31 ibid., pp. 11, 154, 174 - 179.

32 ibid., p. 28.

33 ibid., p. 30.

34 A. Fox, Sociology of Work and Industry, McMillan 1970, pp. 160, 141 - 142.

35 D. Lees, Economics and Non-Economics of the Health Service, Three Banks Review, No. 110, June 1976, pp. 3 - 20.

36 ibid., pp. 3 - 20.

37 H.B. Waitzkin and B. Waterman, The Exploitation of Illness in Capitalist Society, Bob Meril Studies in Sociology, 1974, pp. 69 - 70.

38 D. Dummer, Tomorrows World, Nursing Mirror, Oct. Vol. 155, No. 15, pp. 51 - 53.

39 H. Beynon and R. Blackburn, Perceptions of Work, Cambridge University Press, 1972, pp. 161 - 163.

40 A. Strauss, The Hospital and its Negotiated Order, McMillan, 1903, pp. 141 - 142.

41 B. Abel-Smith, A History of the Nursing Profession, Heinemann, 1960, pp. 148 - 190

42 P. Halmos, op. cit., pp. 155 - 190.

43 H. Becker and J. Carper, The Element of Identification in an Occupation, American Sociological Review, Vol. 23, June 1956, pp. 341 - 346.

44 J. Katan, The Attitude of Professions Towards the Employment of Non-Professionals in Human Service Organisations. Professionalism and Social Change ed., by P. Halmos, University of Keele Monograph, 1973, pp. 229 - 261.

45 M. Williams, Theatre of Protest, Nursing Mirror, Vol. 148, No. 11, 1979, pp. 20 - 22.

46 ibid., pp. 20 - 22.

47 A. Bell, Theatre Nursing in Europe, NAT News, Vol. 19, No. 1., 1982, pp. 12 - 16.

48 G. Salaman, Community and Occupation, Cambridge University Press, 1973, pp. 30 - 32.

49 J. Hudd, Report on Training of O.D.As. NAT News, Vol. 10. No.6, 1973, pp. 6 - 7.

50 P. Halmos, op. cit., pp. 27 - 30, 180.

51 S. Dimmock, Dilemma in Medical Representation, Industrial Relations in the N.H.S., ed., by N. Bosanquet, Kings Edwards Fund, 1977 pp. 199 - 219.

52 ibid., pp. 199 - 219.

53 P. Halmos, op. cit., pp. 23 - 30.

54 ibid., pp. 160 - 169.

55 ibid., pp. 115 - 144.

56 ibid,. pp. 28 - 30.

57 ibid., pp. 196 - 197.

58 ibid., pp. 190 - 192.

59 E. Freidson, 1970, Profession of Medicine, New York: Dodd, Mead.

60 P. Halmos, op. cit., pp. 23 - 25.

61 A.J. Willcocks, The Creation of the National Health Service, Routledge Kegan Paul, 1965, pp. 248 - 249.

62 M. Johnson, Nursing Auxiliaries and Nurse Professionalism, Nursing Times, Feb., Vol. 74, No. 8, 1978, pp. 313 - 317.

63 ibid., pp. 313 - 317.

64 H.B. Waitzkin and B. Waterman, op. cit., pp. 86 - 87.

65 P. Halmos, op. cit., pp. 23 - 28.

66 A.J. Willcocks, Manpower in the 1980's, Hospital and Health Service Review, July 1980, pp. 248 - 249.

67 N. Jeffries, Appraisal of Labour Wastage in the Housekeeping Department of Cardiff Royal Infirmary, Polytechnic of Wales, Dissertation, 1974, p. 14.

68 P. Halmos, op. cit., 55 - 57.

69 P. Hickey, High Speed Life in the Operating Theatres, Health and Social Services Journal, Nov. 3.

70 D. Dummer, op. cit., pp. 51 - 53.

71 P. Hickey, op. cit., pp. 1250 - 1251

72 ibid., pp. 1250 - 1251.

73 ibid., pp. 1250 - 1251.

74 J.C. Taylor, The Threat to Theatre Specialist Unit Managers, Health and Social Service Journal, March, Vol. XCIII, No. 4786, pp.

75 D. Dummer, op. cit., pp. 51 - 53.

76 ibid., pp. 51 - 53.

77 L. Stein, The Doctor - Nurse Game, Readings in the Sociology of Nursing ed., by R. Dinglewell and J. McIntosh, Churchill Livingstone 1978, pp. 109 - 117.

78 B. Abel-Smith, op. cit.,

79 A.J. Willcocks, op. cit., pp. 86 - 93.

80 D. Dummer, op. cit., pp. 51 - 53.

81 A.P.T. Williams, et al., op. cit., pp. 128 - 131.

82 D. Smith, The Forgotten Sector, Pergamon Press, 1969, pp. 160 - 165.

B I B L I O G R A P H Y

Abel Smith, B. (1960) A History of the Nursing Profession, Heinemann.

Aitschul, A.T. Commitment to Nursing, Journal of Advanced Nursing, Vol. 4., March, pp. 123 - 125.

Aiken, M., and Hage, J. (1966) Organisational Alienation, American Sociological Review, Vol. 31. pp. 497 - 507.

Anderson, E. (1973) The Role of the Nurse, Royal College of Nursing.

Argyle, M. (1972) The Psychology of Inter-Personal Behaviour, Pelican.

Argyris, M. (1972) The Applicability of Organisational Sociology, Cambridge.

Baldamus, W. (1951) Types of Work and Motiviation, British Journal of Sociology, Vol. 2. pp. 44 - 58.

Banton, R. (1965) Roles, Tavistock Publications.

Becker, H.S., and Carpenter, J. (1956) The Elements of Identification within an Occupation, American Sociological Review, Vol. 23, pp. 341 - 346.

Bell, (1966) The Predictability of Work Demands and Professionalism as Determinants of Workers Discretion, Journal of Academy of Management, Vol. 9, No. 1. pp. 440 - 487.

Berg, W.K. (1964) Concensus Between Role Expectations and Role Behaviour Among Ministers, Community Mental Health Journal, Vol. 14. pp. 301 - 306.

Beynon, H., and Blackburn, R (1972) Perceptions of Work, Cambridge University Press.

Bishop, C. (1977) Hospitals from Secondary to Primary Labour Market, Industrial Relations, Vol. XVI No. 1., pp. 26 - 34.

Blauner, R. (1964) Alienation and Freedom, University of Chicago.

Blum, A. (1966) Differential Use of Manpower in Publix Welfare, Social Work, Vol. 11, No. 1, January, pp. 16 - 21.

Blumberg, P. (1968) Industrial Democracy, The Sociology of Participation, Constable.

Bramner, L.M. (1979) The Helping Relationship, Prentice Hall.

Briggs Report (1973) Nursing Education, H.M.S.O.

Brophy, A.L. (1959) Self Role and Satisfaction, Genetic Psychology, Monogram, Vol. 59, May, pp. 265 - 301

Brown, E.L. (1972) Nursing and Patient Care, Five Sociological Essays on the Nursing Profession, ed., Davies, E.J. Wiley.

Brown, R (1972) Sources of Objectives in Work, from Man in Organisation, ed., by Childs, J., Allen and Unwin.

Burz, C. (1972) A Study of Role Strain, Dissertation, University of Michigan.

Carkhuaff, R.R., and Truax, C.B. (1965) Journal of Consulting Psychology, Vol. 14, No. 3, pp. 18 - 25.

Carlson, M.M., and Sutton, M.S. (1975) The Effects of Differential Police Roles on Attitudes and Values, Journal of Psychology, Vol 99, pp. 57 - 64.

Carpenter, M. (1978) Managerialism and the Division of Labour, Readings in the Sociology of Nursing, ed., by Dinglewall, R., and McIntosh, J., Churchill and Livingstone.

Carr-Saunders, A.M., and Wilson, R.A. (1933) The Professions, Oxford University Press.

Carter, M (1969) Into Work, Pelican.

Cassel, F.M. (1976) The Direction of Labour Management Relationships in the United States Health Service, British Journal of Industrial Relations, Vol. 14, pp. 18 - 25.

Caplow, F.M. (1954) Sociology of Work, University of Minnesota Press.

Chinoy, E. (1955) Automobile Workers and the American Dream, New York Double Day and Co.

Clarke, J.P. (1959) Measuring Alienation within a Social System American Sociological Review, Vol. 24, Dec. pp. 190 - 195.

Clarke, M. (1978) Getting Through the Work, Readings in the Sociology of Nursing, ed., by Dingwall, R., and McIntosh, J., Churchill and Livingstone.

Coghill, N. (1965) Hospital Internal Communication Project, Report on West Middlesex Hospital.

Coghill, N. (1977) Workers' Participation and Control in Hospitals, Paper presented at the Second International Conference on Participation, Workers' Control and Self Management, Paris 1977.

Cooper, R.C. (1974) Job Motivation and Job Design, Institute of Personnel Management Publication.

Corwin, R. (1961) A Study of Role Conflict in Nursing Roles, American Sociological Review, Vol. 66, pp. 606 - 615.

Coser, R. (1963) Alienation and The Social Structure, The Hospital in Modern Society, ed., by Friedson, E., New York Free Press.

Cotgrove, R., and Box, S. (1967) Scientific Identity Occupational Selection and Role Strain, British Journal of Sociology, Vol. 17, No. 1.

Crichton, A. (1964) Disappointed Expectations, Welsh Hospital Board

Crichton, A. (1964) Hospitals in Transition, Welsh Hospital Board

Cruickshank, A., McManus, C (1976) Getting into Medicine, New Society

Dale, A.J. (1965) Job Satisfaction and Organisation Among Hospital Domestic Workers, British Journal of Industrial Relations, Vol. 3. No. 1, pp. 164 - 169.

Dane, J.H. (1971) Exploring Hospital Turnover, Hospital Topics, Vol. 49, August, pp. 49 - 53.

Davey, M. (1972) Grievances and Discipline in the Southampton University Hospital, Health Services Review, Dec., pp. 445 - 446.

Davies, M.K. (1974) Intra Role Conflict and Job Satisfaction on Psychiatry Units, Nursing Research, Vol. 23, Nov., Dec. pp. 482 - 488.

Davies, F., and Olsen, V (1963) Initiation into a Womens Profession, Sociometric, Vol. 26, March, pp. 186 - 195.

Dean, D. (1961) Alienation the Meaning and Measurement, American Sociological Review, Vol. 26, No. 5, pp. 753 - 757.

Department of Health and Social Security, 1970, The Lewin Report, The Organisation and Staffing of Operating Departments.

Dimmock, S. (1977) Dilemmas of Medical Representation, Industrial Relations in the N.H.S., ed. by R. Bosanquest, King Edward's Fund.

Dubin, R. (1962) Industrial Workers World Human Behaviour and Social Processes ed. by Rose, A.M. Routledge Kegan Paul.

Dummer, D (1982) Tomorrow's World, Nursing Mirror, October, Vol. 155, No. 15.

Durkheim, E.T. (1893) The Division of Labour in Society.

Dyson, R.K. (1973) The Ancillary Staff Industrial Action in Spring 1973, Yorkshire Area Health Authority.

Dorr, D. (1973) The Dimensionality of Test Battery for Non Professional Mental Health Workers, Journal of Consulting Psychology.

Esland, G. (1980) Professions and Professionalism, The Politics of Work and Occupations, ed., by Esland, G., and Salaman, G. Open University Press.

Etzioni, A. (1961) A Comparative Analysis of Complex Organisations, Free Press, New York.

Evans, A.M., and Morgan, W.D. (1964) A Survey of Male Portering Staff in South Wales, Welsh Staff Advisory Board.

Evans, J. (1960) Stratification and Alienation in the Hospital Setting, Ohio State University, University of Columbia.

Faunce, A. (1968) Problems of an Industrial Society, McGraw Hill.

Fieldman, D.C. (1977) Organisational Socialisation of Hospital Employees Medical Care, Vol. 15, No. 10, October.

Fox, A (1971) The Sociology of Work in Industry, McMillan.

Fox, A (1974) Beyond Contract Work Power and Trust Relationships, Faber

Friedman, G (1955) Industrial Society Free Press Glencoe.

Fromm, E (1955) The Sane Society, Reihart and Co., New York.

Fromm, E.(1942) The Fear of Freedom, Routledge Kegan Paul.

Georgopoulos, E., and Mann, F. (1962) The Community General Hospital New York, McMillan.

Gibson, G. (1931) History of Mental Hospitals and Institutions, Express Co-operative Printing Society.

Goffman, E. (1961) Asylums, Garden City New York, Double Day, Anchor

Goldthorpe, J., Lockwood, D., Bechover, J., and Platt, J. (1968) The Affluent Worker, Cambridge University Press.

Goode, W. (1960) A Theory of Role Strain, American Sociological Review, Vol. 24, August, pp. 483 - 496.

Gorham, M. (1974) Joint Consultation, Health and Social Services Review.

Gouldner, A. (1963) The Unemployed Self, Work ed., by Fraser, R. Pelican

Grace, C.M. (1972) Role Conflict and the Teacher, Routledge Kegan Paul.

Greenwood, M. (1957) Concepts of Professionalism Social Work, Vol. 1, No. 3, pp. 41 - 55.

Green, S. (1974) The Hospital as an Organisation, Black

Gross, et al., (1958) Exploration in Role Analysis, Wiley.

Halmos, P. (1966) Faith of the Counsellors, Constable.

Halmos, P. (1970) The Personal Service Society, Constable.

Handschu, S. (1973) Profile of the Nurses Aide, Gereontologist, Oct., 13. pp. 315 - 317.

Haywood, S.C. (1974) Managing the Health Service, Allen and Unwin.

Herzberg, F. (1959) The Motivation to Work, Wiley, New York.

Hespe, G. and Wall, T.D. (1977) Attitudes Towards Participation and Satisfaction Among Nurses, in Worker Participation, ed., by Wall, T.D., and Lischerson, J.A. McGraw Hill, 1977.

Hickson, D.J. (1966) Convergence in Organisation Theory, Administrative Science Quarterly, Vol. 11, No. 2, September, 224 - 237.

Hoggart, R. (1957) The Uses of Literacy, Charles Windus.

Homans, G.C. (1950) The Human Group, Harcourt and World Incorporated.

Hospital Organisation and Method Report, (1960) Hospital Portering, H.M.S.O.

Hospital Organisation and Method Report, (1960) Organisation and Management of Hospital Work, H.M.S.O.

Hudd, J. (1973) Training of Operating Department Assistants, National Association of Theatre Nurses, News, December.

Hudson-Rosen, T. (1970) Foreman Role Conflict, Industrial Labour Relations Review, Vol 23, July, pp. 541 - 551.

Heffries, N. (1975) Appraisal of Labour Wastage in the Housekeeping Department of Cardiff Royal Infirmary, Dissertation, Polytechnic of Wales.

Johnson, M.L. (1978) Nursing Auxiliaries and Nurse Professionalism, Nursing Times, February 23, Vol. 74, No. 8 pp. 313 - 317.

Johnson, M.M., and Martin, A.W. (1957) A Sociological Study of the Nurse Role, American Journal of Nursing, No. 3, pp. 373 - 377.

Kahn, R.L., Wolf, D., Quinn, R., and Snoek, J. (1966) Organisation Stress, Role Conflict, Wiley, New York.

Kahn, R.L., and French, J.L. (1962) A Summary of Some Tentative Conculsions on Work Health and Satisfaction, Journal of Social Issues, Vol. 18, No. 3 pp. 1 - 49

King Edwards VIII Hospital Fund Report, 1963, Report of Working Party on the The Training of Porters.

Kramer, M. (1968) Nurse Role Deprivation, Social Science and Medicine, Vol. 2, pp. 461 - 463.

Krause, E.A. (1976) The Sociology of Occupations, Little Brown and Co.

Lees, D. (1976) Economics and Non Economics of Health Service, Three Banks Review, No. 110, June, pp. 3 - 20.

Lieberman, S. (1956) The Effect of Changes in Roles on Attitudes of Role Occupants, The Journal of Psychology, Vol. 168, pp. 39 - 48.

Levinson, D.J. (1959) Role, Personality and Social Structure, in the Organisational Setting, Vol. 58, pp. 170 - 180.

Mansfield, R. (1972) The Initiation of Graduates in Industry, Human Relations, Vol. 25, No. 1. pp. 77 - 86.

Manson, T. (1977) Management the Professions and the Unions, Health and the Division of Labour, ed., by Stacey, M. London, Croom Hall pp. 196 - 216.

Marsh, D.C., and Willcocks, A.J., (1961) The Recruitment of Nurses, University of Nottingham Research Paper.

Marx, K. Alienated Labour Reprint from Karl Marx, early writings ed., by Bottomore, T, Watts, 1962.

McAll, G.J. (1970) Social Relationships Adine Publishing Co., Chicago.

McCarthy, W.T. (1975) Whitleyism, Health Service Review.

McLoskey, J. (1974) Influence of Rewards and Incentives on Staff Turnover, Nursing Research, Vol. 23, May, June, pp. 239 - 247.

McGuire, J. (1969) Why Girls Go Nursing, Threshold to Nursing, Bell.

Meyer, H.J. (1959) Issues on Social Work, ed., by Kahn, A.J. Columbia Un Press

Middleton, R. (1963) Alienation, Race and Education, American Sociological Review, Vol. 28, Dec. pp.

Ministry of Health Scottish Home and Health Department, Report on Ambulance Training and Equipment, Part 1, Training. 1966. H.M.S.O.

Morse, N.C., and Weiss, R.S. (1955) The Function and Meaning of Work and the Job, American Sociological Review, Vol. 120, pp. 191 - 198.

National Board for Prices and Incomes (1971) Pay and Conditions of Ancillary Workers, Report 161. H.M.S.O.

Newcombe, T. (1952) Social Psychology, A Study of Human Interaction, Routledge and Kegan Paul.

Office of Health Economics, (1975) Sickness Absence, No. 26, April.

Palola, E.G. (1971) Organisation Types and Role Strain, Social Research Review, Vol. 5, Jan. pp. 172 - 183.

Palola, E.G., and Jones, C.J. (1965) Contrasts in Organisational Features and Role Strains between Psychiatric and Paediatric Wards, Journal of Human Behaviour, Vol. 63, Fe. pp. 155 - 163.

Pavalko, R.M. (1972) Sociological Perspectives of Occupations, F.E. Peacock, Illinois.

Pearlin, L.I. (1962) Alienation from Work: A Study of Nursing Personnel American Sociological Review, Vol. 27, 1962, pp. 314 - 326.

Pearlin, L.I., and Rosenburg, M. (1961) Nurse Patient Relationship American Sociological Review, Vol. 27, No. 1, 1961, pp. 56 and 57.

Pearlman, H.H. (1968) Personal Social Role and Personality, University of Chicago Press.

Perrow, C. (1965) Hospital Technology Structure and Goals, ed., by Marsh. C., Rand McNilly.

Pettigrew, A.M. (1975) Occupational Specialisation, An Emergent Process, in People at Work, ed., by Esland, G.M., Salaman, J.G., and Speakman, M. Holmes-McDougall

Poser, E.G. (1966) The Effects of Therapist Training on Group Therapeutic Outcome, Journal of Consulting Psychology, Vol. 30, No. 4, pp. 285 - 288

Quinney, E. (1964) Adjustment to Occupational Role Strain, The Case of Retail Pharmacy, South Western Social Science Quarterly, March, pp. 367 - 376

Rice, G. (1977) Labour Turnover in a Hospital, University of Wales, Institute of Science and Technology Dissertation

Revans, R.M. (1964) Standards of Morale: Cause and Effects in Hospitals, Oxford University Press.

Riessman, F. (1965) The Helper Theory Principle, Social Work, Vol. 10, No. 2, pp. 27 - 32

Riessman, F. (1967) Gap Strategies and Suggestions for Training Non-Professionals, Community Health Journal, Vol. 3, No. 2, pp. 103 - 110

Roberts, A. (1964) Head Porters and Porters in Hospitals, Hospital, Jan. 1964.

Robinson, D. (1974) Patients Practitioners, and Medical Care, Heinemann

Roth, J.A. (1962) The Treatment of Tubercolosis as a Bargaining Process, Human Behaviour and Social Action, ed., by Rose, A., Routledge Kegan Paul

Rubington, E. (1956) Organisation Strains and Key Roles, Administrative Science Quarterly, Vol. 9, pp. 351 - 367

Salaman, G. (1972) Community and Occupation, Cambridge University Press

Salaman, G. (1982) Class and Corporation, Fontana

Saunder, K. (1979) The Hospital Porter, Employee Relations, Vol. 1, No. 4, pp. 30 - 32

Schacht, R. (1971) Alienation, Allen and Unwin

Schmitt, R. (1968) Role Conflict, in Nursing American Journal of Nursing, Vol. 68.

Scott, W.M. (1956) Technical Change and Industrial Relations, Liverpool University Press

Seecord, P.F. and Backman, W.B. (1967) Social Psychology, McGraw Hill

Seeman, M. (1967) On the Personal Consequences of Alienation in Work, American Sociological Review, Vol. 32., April.

Sharma, B. (1971) Commitment to Industrial Work, Indian Journal of Industrial Relations, Vol. 4, No. 1, pp. 3 - 30

Shepard, J. (1972) Alienation as a Social Process, Sociological Quarterly, Vol. 13, No. 2 pp. 161 - 173

Sherlock, B. and Cohen, A. The Strategy of Occupational Choice, Recruitment to Dentistry, Social Forces, Vol. 44, March 1966, pp. 301 - 313

Shibutani, T. (1955) Reference Groups as a Social Control, American Journal of Sociology, Vol. 60 pp. 562 - 569

Simpson, I.H. (1967) Patterns of Socialisation into Professions, The Case of the Student Nurse, Sociological Enquiry, No. 7, Winter, pp. 47 - 54.

Siebert, W.S. (1977) Occupational Licensing the Merrison, Report on the Regulations of the Medical Profession, British Journal of Industrial Relations, Vol. 15, 1977, pp. 29 - 35

Slocum, J.W. Jr., Susman, G.I. and Sheridan, J.F. (1972), An Analysis of Need Satisfaction and Job Performance Among Professional and Para Professional Hospital Personnel, Nursing Research, Vol. 21, No. 4, pp. 338 - 341

Simmel, G. (1950) The Sociology of George Simmel, Kurt Wolff Translation, The Free Press of Glencoe, New York, 1950

Smith, D. (1969) The Forgotten Sector, Training of Ancillary Staff in Hospitals Pergammon Press

Stannard, C. (1978) Old Folks and Dirty Work, Readings in Sociology of Nursing ed. by Dingwall, R. and McIntosh, J. Churchill Livingstone

Strauss, A. (1971) The Professions Work and Careers, Sociology Press

Strauss, A. (1963) The Hospital in Modern Society, ed. by Friedson, E. Macmillan

Sugden, J. (1975) Health and Hospitals Service Review, May.

Susman, G. (1972) Process Design and Automation and Worker Alienation, Industrial Relations, Vol. 11, Feb. pp. 34 - 41

Tausky, C. and Wilson, W. (1971) Work Attachment Among Blackmen, Phylon, Spring

Tichsler, G. (1972) The Transition into Residency, Americal Journal of Psychiatry, Vol. 128, No. 9, March, pp. 1103 - 1111

Titmuss, R.M. (1958) Essays on the Welfare State, Unwin

Titmuss, R.M. (1968) Commitment to Welfare, Unwin

Thomson, J. (1969) Survival of Joint Consultation, British Hospital Journal, and Social Service Review, Vol. 79

Tomlin, P. (1977) Psychological Problems in Intensive Care, British Medical Journal, August, Vol. No. 2, pp. 441 - 443

Tonnies F. (1963) Community and Society, translated and edited by Lomas, C, New York Harbour Torchbook.

Trail, I. (1971) The Relationship of Role Conflict and Alienation, Dissertation, University of California, pp. 124 - 144

Tudor, W. (1972) A Specification of the Relationship Between Job Complexity and Powerlessness, American Sociological Review, Vol. 37, pp. 596 - 602

Turner, B. (1971) Exploring the Industrial Subculture, Macmillan

Unit for the Study of Health Policy, (1978) The N.H.S. in the Next 30 Years, Guy's Hospital Publication.

Vroom, V.H. (1964) Work and Motivation, Wiley and Son

Waitzkin, H.B. and Waterman, B. (1974) The Exploitation of Illness in Capitalist Societies, Bob Merril Studies in Sociology

Wall, T. and Lischerson, J.A. (1977) Worker Participation, McGraw Hill

Watson, T.H. (1980) Sociology of Work and Industry, Routledge Kegan Paul

White, H.C. (1971) Leadership: Some Behaviours and Attitudes of Hospital Employees, Hospital Progress, October, 1971

Willcocks, A.J. (1967) The Creation of the National Health Service, Routledge Kegan Paul

Willcocks, A.J. (1981) Manpower for 1980's, Hospital and Health Service Review, July, pp. 248 - 249

Wilensky, H. (1964) Work as a Social Problem, Work Leisure and Freedom, Free Press, Glencoe, pp. 117 - 166

Wilensky, H. (1970) The Professionalisation of Everyone, The Sociology of Organisations, ed., by Grunsky, O. and Millar, G.A., Free Press of Glencoe

Williams, A.P., Livey, L., Silverstone, R. and Adams, P. (1977) The Recruitment of Hospital Ancillary Staff, Final Report to the D.H.S.S., City of London Business School

Williams, K. (1974) Ideologies of Nursing, Nursing Times, August 8th, 1974

Willmot, P. (1969) Adolescent Boys of East London, Pelican

Wilson, D. (1972) The Dock Worker, Fontana

Woodward, J. (1948) Employment Relations in a Group of Hospitals, Institute of Hospital Administrators Publication

Woodward, J. (1965) Industrial Organisations, Oxford University Press

Wolfe, D. and Snoeke, E. (1962) A Study of Tensions and Adjustments Under Role Conflict, Journal of Social Issues No. 3, pp. 102 - 121

Zijderfield, A.C. (1972) The Abstract Society, Pelican